

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27375**

FILED AUG 10 1953

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **161**

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
c. LENGTH OF STAY (in this place) 8 days		d. STREET ADDRESS (If rural, give location) 576 West Boyd	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Hospital			
3. NAME OF DECEASED a. (First) Quillia Mae b. (Middle) Burnett c. (Last) Duncan			4. DATE OF DEATH (Month) (Day) (Year) Aug. 6th, 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 5th, 1888
9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 100 YRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Saline County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William R. Burnett		13b. MOTHER'S MAIDEN NAME James Mary Thornton	
14. NAME OF HUSBAND OR WIFE Joseph Duncan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs Louis Ellison, Marshall, Mo.		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Obstruction of bowels & stomach ANTECEDENT CAUSES fibrosis due to ulcer. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Following Surgery 5400 Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Obstruction of bowels - benign	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 11 53 94m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1952 , to Aug 6, 1953 , that I last saw the deceased alive on Aug 6, 1953 and that death occurred at 11 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John P. Lawrence, M.D.		23b. ADDRESS Marshall, Mo.	
23c. DATE SIGNED Aug 7-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-9-1953	
24c. NAME OF CEMETERY OR CREMATORY Ridge Park cemetery		24d. LOCATION (City, town, or county) (State) Marshall, Mo.	
DATE REC'D BY LOCAL REG. Aug 8-1953		REGISTRAR'S SIGNATURE Sidney T. Gray 385	
FUNERAL DIRECTOR'S SIGNATURE Campbell-Lewis		ADDRESS Marshall, Mo.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *James H. Lewis Jr.*

Licensed Embalmer No. *4709*

P. O. Address *Marshall, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.