

FILED JUN 9 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16597**

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **3041** Registrar's No. **230**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Iowa b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION Damaritan Hosp.		d. STREET ADDRESS (If rural, give location) 50 1/2 S. 6th	

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Mathew c. (Last) BURNS			4. DATE OF DEATH (Month) (Day) (Year) May 14 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 19, 1908	9. AGE (In years last birthday) 46	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Iowa	

13a. FATHER'S NAME Walter Burns	13b. MOTHER'S MAIDEN NAME Florence Sattberg	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2	16. SOCIAL SECURITY NO. 484-03-6114	17. INFORMANT'S SIGNATURE OR NAME J.P. Platt ADDRESS Fairfield Iowa	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Inst
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Angina Pectoris DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lester Hutton Coronar	23b. ADDRESS Macon Mo.	23c. DATE SIGNED May 13, 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 17, 54	24c. NAME OF CEMETERY OR CREMATORY Fairfield Cem.	24d. LOCATION (City, town, or county) (State) Fairfield Iowa
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DATE REC'D BY LOCAL REG. 5/22/54	REGISTRAR'S SIGNATURE Juth McNeely	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lester Hutton Macon Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

MACON COUNTY HEALTH DEPARTMENT

County File No.

Date Filed

6.7.54

6.57.92

6.8.54

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

Charles L. Hutton

Licensed Embalmer No.

4577

P. O. Address

Macon, 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.