

FILED OCT 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33721

State File No.

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Fayette, Missouri)		c. LENGTH OF STAY (in this place) 17 Months	c. CITY OR TOWN Armstrong
d. FULL NAME OF HOSPITAL OR INSTITUTION Wells Rest Home		STREET ADDRESS (If rural, give location) R. R. 1	

3. NAME OF DECEASED (Type or Print) Frank	a. (First)	b. (Middle)	c. (Last) Burgin	4. DATE OF DEATH (Month) (Day) (Year) Oct. 10, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/1/1872	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 9	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (City and State or Foreign Country) Richmond Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Eason Burgin	13b. MOTHER'S MAIDEN NAME Mary Fowler	14. NAME OF HUSBAND OR WIFE Duck Parke
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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 W. E. Batterton	ADDRESS R.R. 1 Armstrong Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized DUE TO (c) unknown		
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 332X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from Jan 1, 1953, to Oct 10, 1954, that I last saw the deceased alive on October 9, 1954, and that death occurred at 7:30am. from the causes and on the date stated above.

23a. SIGNATURE James A. Dean M.D.	(Degree or title)	23b. ADDRESS Fayette, Mo	23c. DATE SIGNED 10-12-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/12/1954	24c. NAME OF CEMETERY OR CREMATORY Richmond Cemetery	24d. LOCATION (City, town, or county) (State) Richmond Kentucky
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DATE REC'D BY LOCAL REG. 10-12-54	REGISTRAR'S SIGNATURE Mary K. Shell	436	25. FUNERAL DIRECTOR'S SIGNATURE Ralph A. Carr	ADDRESS Fayette, Missouri
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 23 1958

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, ~~and~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Ralph A. Carr*

Licensed Embalmer No. *331*

P. O. Address *Fayette,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.