

FILED NOV 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34342

State File No.

BIRTH NO.		REG. DIST. NO. <u>157</u>		PRIMARY REG. DIST. NO. <u>3028</u>		Registrar's No. <u>219</u>	
1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		c. LENGTH OF STAY (in this place) <u>10 da.</u>		c. CITY OR TOWN <u>Carthage</u>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McCune-Brooks Hospital</u>				STREET ADDRESS (If rural, give location) <u>816 River</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amy</u> b. (Middle) <u>Blanch</u> c. (Last) <u>Haggard</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 29 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-13-1875</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired grocer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sarcoxie, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W. T. Burkholder</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy</u>		14. NAME OF HUSBAND OR WIFE <u>Will Haggard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Cloyd Burkholder, Rt 1, Grandy, Mo.</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Hypertensive heart disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>Several yrs</u> <u>2-3 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443 X</u>				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 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 <u>April</u> , 19 <u>48</u> , to <u>10-29</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10-28</u> , 19 <u>54</u> , and that death occurred at <u>1:46 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W Russell Smith</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>Carthage, Mo</u>		23c. DATE SIGNED <u>10-29-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 1, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sarcoxie, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-30-54</u>		REGISTRAR'S SIGNATURE <u>W H Clenton</u> <u>139</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Knell Mortuary, Carthage, Mo.</u>			

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

Date Filed NOV 0 1954

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..... Signature of Student Embalmer

Signed..... Robert H. Knell

Licensed Embalmer No. 445

P. O. Address Carthag

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.