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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

592

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 13 1957

STATE FILE NUMBER 3549

Registration District No. 373 Primary Registration District No. 6269 Registrar's No. #5

1. PLACE OF DEATH
a. COUNTY: WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: OZARK — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: WEBSTER
c. CITY OR TOWN: MARSHFIELD R2 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 2 mi W — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JAMES; Middle: A; Last: BURTNER

4. DATE OF DEATH: Month: JAN; Day: 23; Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: OCT 31 1880

9. AGE (In years last birthday): 76

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: GEORGE BURTNER

14. MOTHER'S MAIDEN NAME: CATHERINE WILSON

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.:

17. INFORMANT: HOMER BURTNER — Address: SPRINGFIELD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Anemia — INTERVAL BETWEEN ONSET AND DEATH: Year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis, Severe — 10 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 334X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 1946, to Jan. 23 57 and last saw her/him alive on Jan. 22, 1957. Death occurred at 4:25 A. m on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE: C. P. MacDonnell (Degree or title): M.D.

22b. ADDRESS: Marshfield, Mo

22c. DATE SIGNED: 1/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 1-27-1957

23c. NAME OF CEMETERY OR CREMATORY: TIMBER RIDGE

23d. LOCATION (City, town, or county): WEBSTER CO — (State): MO

24. FUNERAL DIRECTOR — ADDRESS: BARBER-EDWARDS MARSHFIELD

25. DATE RECD. BY LOCAL REG.: 1-29-57

26. REGISTRAR'S SIGNATURE: J. Francis

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.