

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41098

STATE FILE NUMBER

FILED DEC 11 1957

Registration District No. 200 Primary Registration District No. 5775 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Monroe</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hudson Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Paris</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Elizabeth's Hospital</u> <u>John Hildreth San System</u>				Length of stay in lb <u>3 yrs 6 mo</u>		d. STREET ADDRESS (If outside, give location) <u>W. Locast St</u>	
3. NAME OF DECEASED (Type or print) <u>JENNIE Caldwell Buerke</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28 1869</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Month <u>3</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>Monroe Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tyre Tipton Rodes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Blakey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>N. C. RODES, PARIS, MO.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Encephalomalacia</u> DUE TO (c) <u>Arteriosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>"</u>				
20c. TIME OF INJURY Hour <u>11:45 P.M.</u> Month <u>Nov</u> Day <u>28</u> Year <u>1957</u> a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Paris Mo</u>		COUNTY STATE	
21. I attended the deceased from <u>May 20 1954</u> to <u>Nov 28 1957</u> and last saw <u>her</u> alive on <u>Nov 28 1957</u> . Death occurred at <u>11:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H P Boyle</u> (Degree or title)				22b. ADDRESS <u>D.O. 2 Macon Mo</u>		22c. DATE SIGNED <u>Nov 29 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11/20/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>		23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>		
24. FUNERAL DIRECTOR <u>Speed &amp; Blakey</u>			ADDRESS <u>PARIS, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12/17/57</u>	26. REGISTRAR'S SIGNATURE <u>Ruth M. Sweeney</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

Securing the medical certificate in this department is the responsibility of the embalmer. Requested by 1733-140-1000

HEALTH DEPARTMENT  
County File No. 18.52 203  
Date Filed 12.10.57

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 *E. W. Agnew*.....

Licensed Embalmer No. 400

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