

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028568
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 110

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Kansas City 3198</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Odd Fellows Home</u> | | Length of stay in lb <u>6 Days</u> | d. STREET ADDRESS (If outside, give location) <u>3711 East 11th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>C.</u> Last <u>BURNS</u> | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1958</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>6-24-1869</u> | 9. AGE (in years, months, days) <u>89</u> | 10. FUNERAL YEAR Months <u>8</u> Days <u>1</u> 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>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Graham, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|-----------------------------------|---|---|

| | | |
|--|--|--|
| 13a. FATHER'S NAME <u>Abner D. Sewell</u> | 13b. MOTHER'S MAIDEN NAME <u>Caroline Stowe</u> | 14. NAME OF HUSBAND OR WIFE <u>Robert Burns</u> |
|--|--|--|

| | | |
|--|--|---|
| 15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Mrs. J. T. Rodgers</u> Address <u>Indep., Mo.</u> |
|--|--|---|

| | | |
|--|------------------|---|
| 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>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Year</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ | |
| | DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500F</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | |
|---|---|
| 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>Hip fracture about Aug 1</u> |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |

| | | |
|---|--|---|
| 20d. INJURY OCCURRED WHILE AT <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>Liberty</u> COUNTY _____ STATE _____ |
|---|--|---|

21. Attended the deceased from Aug 3 to Aug 11 and last saw her alive on Aug 10
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|--|-----------------------------------|--|
| 22a. SIGNATURE <u>W. H. Goodson</u> (Degree or title) <u>M.P.</u> | 22b. ADDRESS <u>Liberty Mo</u> | 22c. DATE SIGNED <u>8/13/58</u> (State) |
|--|-----------------------------------|--|

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8-12-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u> | 23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u> |
|---|-----------------------------|---|--|

| | | |
|---|--|--|
| 24. FUNERAL DIRECTOR <u>Freemore Mortuary</u> ADDRESS <u>K. C. Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-15-58</u> | 26. REGISTRAR'S SIGNATURE <u>Nabel Graham</u> |
|---|--|--|

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



H. H. Goodson

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 *J. P. Freeman*

Licensed Embalmer No. *2939*
P. O. Address *H. CO TN*

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.