

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041173

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 314 Primary Registration District No. 6057 Registrar's No. 49

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>ST. CLAIR</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. CLAIR</u>		
b. CITY OR TOWN <u>CENTER TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>CENTER TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CENTER TOWNSHIP</u>		Length of stay in 1b <u>1 yr</u>	d. STREET ADDRESS (If outside, give location) <u>OSCEOLA, RR # 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY T BOURLAND</u>			4. DATE OF DEATH Month Day Year <u>Nov. 9, 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 15-1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST CLAIR CO MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>MCCAIG Bourland</u>		13b. MOTHER'S MAIDEN NAME <u>JANE PACER</u>	
14. NAME OF HUSBAND OR WIFE <u>REBECCA Bourland</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>498-42-8300</u>	
17. INFORMANT <u>Rebecca Bourland Osceola 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>CARDIAC F SYSTOLE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 MIN.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>STOKES - ADAMS SYNDROME</u>		DUE TO (c) <u>UNKNOWN</u>		<u>443X</u>	
DUE TO (a) <u>HYPERTENSION</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"/>	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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 COUNTY STATE	
21. I attended the deceased from <u>SEPT. 1957</u> to <u>NOV. 8, 1958</u> and last saw him alive on <u>NOV. 8, 1958</u> Death occurred at <u>12:30 PM.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>H. L. Shipman, D.O.</u>		22b. ADDRESS <u>OSCEOLA, Mo.</u>	
22c. DATE SIGNED <u>11-10-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-12-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loury city</u>		23d. LOCATION (City, town, or county) (State) <u>Loury city MO</u>			
24. FUNERAL DIRECTOR <u>Frederick Home Osceola MO</u>		ADDRESS <u>Osceola MO</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-58</u>	
26. REGISTRAR'S SIGNATURE <u>Paul S. Beavers</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

10/11/86 JMC SM

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.B. [Signature]* .....

Licensed Embalmer No. *3038* .....

P. O. Address *Osceola, 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.