Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006112
STATE FILE NUMBER

FILED MAR 11 1959 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY Jasper
b. CITY OR TOWN Carthage — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION McCune-Brooks Hospital — Length of stay in Hospital 14 wks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jasper
c. CITY OR TOWN Sarcoxie c 490 0 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Route #2 — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First: Ellen Middle: Amelia Last: Burgi

4. DATE OF DEATH Month Day Year: Feb. 28, 1959

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: Dec. 13, 1879
9. AGE (In years last birthday): 79 — 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): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): Montgomery County, Md. USA 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: William H. Boyd
13b. MOTHER'S MAIDEN NAME: Elizabeth Hinton
14. NAME OF HUSBAND OR WIFE: John T. Burgi

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.: None
17. INFORMANT: Harold Burgi Address: Sarcoxie, Mo. Rt. #2

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) Pneumonia of Primary Stroke — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.
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): Myocarditis Chronic 1810
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 2-20-57 to 2-28-59 and last saw her/him alive on 2-28-59
Death occurred at 12:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. D. 0
22b. ADDRESS: Carthage, Mo.
22c. DATE SIGNED: 2-28-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-3-59
23c. NAME OF CEMETERY OR CREMATORY: Greys Point Cemetery
23d. LOCATION (City, town, or county) (State): Lawrence County, Mo.

24. FUNERAL DIRECTOR: Knell Mortuary ADDRESS: Carthage, Mo.
25. DATE RECD. BY LOCAL REG.: 3-3-59
26. REGISTRAR'S SIGNATURE: [signature]

(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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. T. McNew,

MAR 17 1959

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. 4459

P. O. Address Carthage, 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.