

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009309
STATE FILE NUMBER
1122

MAR 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4001 Warwick		Length of stay in lb 46 yrs.	d. STREET ADDRESS (If outside, give location) 110 North Brighton
3. NAME OF DECEASED (Type or print) First Ollie Middle W. Last Burns		4. DATE OF DEATH Month March Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1882
9. AGE (In years (last birthday)) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (City and state or country) Golden City, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME J. A. Williamson		13b. MOTHER'S MAIDEN NAME Sophie Goss	14. NAME OF HUSBAND OR WIFE Algie Burns
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. R. K. Nelson K.C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 2 days
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)			
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.) 42221		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Oct 25 1958 , to Feb 28 59 and last saw her alive on Feb 28, 1959 Death occurred at 10:15 AM March 1959 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Orval J. Needels MD (Degree or title)		22b. ADDRESS 7400 Wornall K.C. Mo.	22c. DATE SIGNED March 2 59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/3/59	23c. NAME OF CEMETERY OR CREMATORY Mt Washington	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 3-2-59	26. REGISTRAR'S SIGNATURE Neva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.



Mr. 3-5121
1-4:30pm

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. L. Turner*

Licensed Embalmer No. *4635*
P. O. Address *R. C. No*

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.