

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022744

STATE FILE NUMBER

2 6189

FILED JUL 13 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

300

1-57

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I

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MOUNDS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in lb 25 days	d. STREET ADDRESS (If outside, give location) 718 N. Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALLIE Middle V. Last BUREN			4. DATE OF DEATH Month JUNE Day 29 Year 1959		
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1887	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 0 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Obion Co. Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Dave Johnson		13b. MOTHER'S MAIDEN NAME Josie Miller		14. NAME OF HUSBAND OR WIFE U. S. A.	
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.	17. INFORMANT Idabelle Allen Address 718 N. Main St. Mounds City, Ill.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE					INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE					YEARS
DUE TO (c) _____					443 x 4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POST-OP ABDOMINAL PERINEAL RESECTION FOR CARCINOMA OF RECTUM					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 JUNE 4, 1959 to JUNE 29, 1959 and last saw her alive on JUNE 29, 1959 Death occurred at 5:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. O. Venilton, M.D.</i> (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 6/29/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Cairo & Beechwood		23d. LOCATION (City, town, or county) (State) Mounds Ill.
24. FUNERAL DIRECTOR J. H. RANDLE & SON ADDRESS 3133 Bell Ave.		25. DATE RECD. BY LOCAL REG. JUN 30 '59		26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i>	

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 *Ethel N. Harris*

Licensed Embalmer No. *4458*
P. O. Address *4181 Wash*

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.