

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025825

FILED VS AUG 1 0 1959

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 68

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford</u>		Length of stay in 1b <u>3 days</u>		c. CITY OR TOWN <u>Troy</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>Lincoln County Mem. Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>920 Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>HARRISON</u> Last <u>BURGESS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1959</u>				
5. SEX <u>Male</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>Nov. 3, 1875</u>	9. AGE (last birthday) <u>83</u>			IF UNDER 1 YEAR IF UNDER 24 HR Months <u>8</u> Days <u>28</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Troy MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Matt Burgess</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Giles</u>			14. NAME OF HUSBAND OR WIFE <u>Lena Burgess</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>495-30-8730</u>		17. INFORMANT <u>Mrs Bob Gilliland</u> Address <u>Troy 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>Mesenteric Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNK</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</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.)			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>						
20d. INJURY OCCURRED WHILE AT WORK <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>7/29/59</u> to <u>Aug 1, 1959</u> and last saw her/him alive on <u>8/1/59</u> Death occurred at <u>1:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) <u>Louis P. Hettler MD</u>				22b. ADDRESS <u>Troy, MO</u>		22c. DATE SIGNED <u>8-2-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hawkpoint Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hawkpoint MO.</u>		(State)	
24. FUNERAL DIRECTOR <u>D. W. McCoy</u> ADDRESS <u>Troy Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-2-1959</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed D. D. McCoy

Licensed Embalmer No. 3582

P. O. Address Jay 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.