

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028213

FILED VS AUG 24 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 841

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 27 years		c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2716 Faraon St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Romelia Last Burnett			4. DATE OF DEATH Month August Day 10 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1889	9. AGE (last birthday) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Founder Burnett Auto Parts Co.		10b. KIND OF BUSINESS OR INDUSTRY Eldorado, Illinois.		11. BIRTHPLACE (City and state or country) USA		
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William Frederick Burnett		13b. MOTHER'S MAIDEN NAME Ada Price		
14. NAME OF HUSBAND OR WIFE Marion C. Burnett		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. 500-36-1669		17. INFORMANT Address Mrs. Marion C. Burnett St. Joseph, 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) Brain aneurysm DUE TO (b) See Part II DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Cerebral Aneurysms. 1953-1959				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ p.m.	Month, Day, Year _____					
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 July 5, 1955 to Aug 19, 1957 and last saw him alive on Aug 10, 1957 Death occurred at 10:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE William H. Ames, M.D. (Degree or title)			22b. ADDRESS 902 Edmond St. Joseph, Mo		22c. DATE SIGNED 8-14-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 12, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo. (State)			
24. FUNERAL DIRECTOR Wm. H. Ames, M.D. ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Aug. 17, 1959	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell			

DOCUMENT

Wm. H. Ames, M.D. 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 _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lyle J. Cheng

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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.