

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028378

FILED VS SEP 15 1959

53 Primary Registration District No. 3010 Registrar's No. 314

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 2 days		c. CITY OR TOWN Hot Springs		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Southeast Mo. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.F.D. #5 Box 525		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lillian Middle Hagedorn Last Burneson				4. DATE OF DEATH Month September Day 1 Year 1959					
5. SEX Female	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 12/16/91	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Wm. H. Hagedorn			13b. MOTHER'S MAIDEN NAME Anna Schaumberg			14. NAME OF HUSBAND OR WIFE John Burneson			
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 John Burneson Hot Springs, Ark.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis ± 48 hours DUE TO (b) Arterio Sclerosis heart disease DUE TO (c) Arterio Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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 a.m. 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, etc.) August 31, 1959		20f. CITY, TOWN, OR LOCATION Hot Springs, Ark.		COUNTY		STATE	
21. I attended the deceased from September 1, 1959 and last seen alive on Sept 6, 1959 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE John Crowe MD (Degree or title)				22b. ADDRESS Cape Girardeau Mo.				22c. DATE SIGNED Sept 13, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/4/59/	23c. NAME OF CEMETERY OR CREMATOR Oak Grove Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)		
24. FUNERAL DIRECTOR C. J. Lorberg Cape Girardeau, Mo.				25. DATE RECD. BY LOCAL REG. 9-8-59		26. REGISTRAR'S SIGNATURE Irene Kasten			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

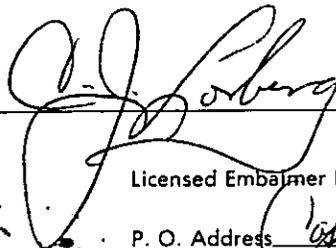
NOV 10 1959

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

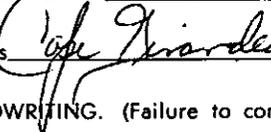
Signed



Licensed Embalmer No.

3810

P. O. Address



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.