

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036780

FILED VS OCT 21 1959 383

Registration District No. _____ Primary Registration District No. 5655 Registrar's No. 114

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Caldwell</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in lb <u>1054 days</u>		c. CITY OR TOWN <u>Cameron</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Fredrick</u> Last <u>Burkhart</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Cameron, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John Fredrick Burkhart</u>			13b. MOTHER'S MAIDEN NAME <u>Millie Filley</u>			14. NAME OF HUSBAND OR WIFE <u>Lola Burkhart</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>San records, Mo. State San. Mt. Vernon</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis Far Advanced</u>						<u>abt. 12</u>		
DUE TO (b) _____						years		
DUE TO (c) _____						Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ 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 bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>11-15-56</u> , to <u>10-5-59</u> and last saw him alive on <u>10-5-59</u> Death occurred at <u>10:15 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				* * * * *				
22a. SIGNATURE (Degree or title) <u>Dr. Raphael M.D.</u>				22b. ADDRESS <u>Mt. Vernon, Missouri</u>		22c. DATE SIGNED <u>10-7-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		23b. DATE <u>10-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <u>Cameron</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Max L. Fozell</u>			25. DATE RECD. BY LOCAL REG. <u>10-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max L. Fournet

Licensed Embalmer No. 4252

P. O. Address McKernan

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.