

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 15 1959

59-039505

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 91

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dent</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u> Length of stay in 1b <u>2 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u> c. CITY OR TOWN <u>Salem</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1st and Henderson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Rufus</u> Middle <u>George</u> Last <u>Burns</u>			<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>7</u> Year <u>1959</u>				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-11-88</u>	<b>9. AGE (last birthday)</b> <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>general</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Dent Co Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U S A</u>	
<b>13a. FATHER'S NAME</b> <u>Joe Burns</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Rebecca Skeeters</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Ruth Rodgers Burns</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>X</u>		<b>17. INFORMANT</b> <u>Mrs Ruth Burns Salem Mi</u> Address _____		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute CARDIAC Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute CORONARY Occlusion</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchial Asthma</u>					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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE _____	
<b>21. I attended the deceased from</b> <u>August 1959</u> to <u>12/7/59</u> and last saw her/him alive on <u>12/7/59</u> Death occurred at <u>2:25 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>B. J. Bass, MD</u>				<b>22b. ADDRESS</b> <u>Salem Mo</u>		<b>22c. DATE SIGNED</b> <u>12/8/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>23b. DATE</b> <u>12-9-59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>North Memorial Cem</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Dent Co Mo</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Spencer Funeral Home Inc</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>12/9/59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>M. M. Hart, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS  
AUG 5 1964

**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 Carl H. Dyer

Licensed Embalmer No. 237

P. O. Address Salina

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.