

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 4 6 9 0

FILED VS DEC 21 1959

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 85

STATE FILE NUMBER

UNDECEASED

|  |   |  |  |   |  |  |                                  |
|--|---|--|--|---|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Linn</u>   |   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>Linn</u> |  |  |                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>   |   | Length of stay in 1b <u>4 M.</u>   |  | c. CITY OR TOWN <u>Marceline</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bunton Rest Home</u>  |   |  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location) <u>217 E. Chicago</u>                  |                                  |
| 3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>Clyde</u> Last <u>Burch</u>   |   |  |  | 4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>59</u>   |  |  |                                  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>   | 7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-29-1875</u>   | 9. AGE (last birthday) <u>84</u>  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>12</u>  | IF UNDER 24 HR<br>Hours <u></u> Min. <u></u>   |                                  |
| 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>Retired</u>   |  | 11. BIRTHPLACE (City and state or country) <u>Linn, Co.</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |                                  |
| 13a. FATHER'S NAME <u>Dennis</u>   |   |  | 13b. MOTHER'S MAIDEN NAME <u>Stella Bancroft</u>   |   | 14. NAME OF HUSBAND OR WIFE <u>Millie</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></u>  |  | 17. INFORMANT <u>Mrs Millie Burch Marceline MO</u><br>Address <u></u>   |  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO (b) <u>CEREBROVASCULAR ACCIDENT</u><br>DUE TO (c) <u></u><br>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) <u>COMATOSE RESPIRATORY DISTRESS</u>   |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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<br>Hour <u></u> Month, Day, Year <u></u><br>a.m. <u></u> p.m. <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>1955</u> to <u>1959</u> and last saw <sup>her</sup> him alive on <u>DEC 10, 1959</u><br>Death occurred at <u>4:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |  |  |   |  |  |                                  |
| 22a. SIGNATURE <u>George Spaw</u> (Degree or title)  |   |  | 22b. ADDRESS <u>121 N. KANSAS AVE MARCELINE, MO.</u>   |   |  | 22c. DATE SIGNED <u>12-12-59</u>   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>   |   | 23b. DATE <u>12-13-59</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. O'NEAL</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Marceline, MO</u>                   |                                  |
| 24. FUNERAL DIRECTOR <u>James McLaughlin Marceline, MO</u> ADDRESS <u></u>   |   |  | 25. DATE RECD. BY LOCAL REG. <u>12-12-59</u>   |   | 26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>   |  |                                  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 13 1960

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 Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address Brown

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.