

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000647

FILED VS FEB 5 1960 59

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 22

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AUSTIN Twp.</u>		Length of stay in lb <u>10 yrs</u>		c. CITY OR TOWN <u>GARDEN CITY</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>5 miles SE Archie</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John William</u> Middle <u>BURGESS</u> Last _____				4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1960</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>9-14-1910</u>	9. AGE (last birthday) <u>49</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>DAIRY MAN</u>		11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William H. Burgess</u>			13b. MOTHER'S MAIDEN NAME <u>VENA DANIELS</u>			14. NAME OF HUSBAND OR WIFE <u>GRACE BENTLEY BURGESS</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>374 05 8133</u>		17. INFORMANT Address <u>GRACE BURGESS R12 GARDEN CITY MO.</u>					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest + ruptured lungs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Crushed by tractor</u>							
		DUE TO (c) _____							
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 checked="" 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.) <u>Tractor turned over on him.</u>							
20c. TIME OF INJURY Hour <u>8:53</u> a.m. Month, Day, Year <u>Jan 22/60</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20e. CITY, TOWN, OR LOCATION <u>AUSTIN Twp.</u>		COUNTY <u>CASS</u>		STATE <u>MO.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>8:53</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert C. Phillips D.C. coroner</u>				22b. ADDRESS <u>302 S. Independence St</u>		22c. DATE SIGNED <u>1/22/60</u>		(State) <u>MO.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS Cemetery</u>		23d. LOCATION (City, town, or county) <u>Raytown, Missouri</u>				
24. FUNERAL DIRECTOR <u>Atkinson Dickey Harrisonville, MO.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sebrer</u>		

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

Student _____

Signature of Student Embalmer

Signed

Robert W Atkinson

Licensed Embalmer No. 4902

P. O. Address Harrisonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to conform 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.