

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009707

FILED VS MAR 7 1960

Registration District No. 379 Primary Registration District No. 4553 Registrar's No. 5

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Wright</u> b. CITY (if outside corporate limits, give TOWNSHIP, only) OR TOWN <u>MANSfield</u> Length of stay in 1b <u> </u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MANSfield Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Wright</u> c. CITY OR TOWN <u>MANSfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u> </u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Cecelia</u> Last <u>Beushausen</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 30 1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>BARABOO Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Burdick</u>		13b. MOTHER'S MAIDEN NAME <u>McGuire</u>		14. NAME OF HUSBAND OR WIFE <u>Otto - Deceased</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>L.H. Beushausen MANSfield Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Cause unknown</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Wremia</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	
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 <u> </u> Month, Day, Year <u> </u> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>2-2-60</u> to <u>2-6-60</u> and last saw her/him alive on <u>2-6-60</u> Death occurred at <u>10:30</u> P m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Ernest Barrett DO.</u>			22b. ADDRESS <u>Mansfield, Mo.</u>		22c. DATE SIGNED <u>2-10-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Feb. 10, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MANSfield</u>		23d. LOCATION (City, town, or county) (State) <u>MANSfield MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Max & Miller Mansfield Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>2/13/60</u>		26. REGISTRAR'S SIGNATURE <u>Stan Purdys</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 7 1960

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 Max J Miller

Licensed Embalmer No. 4720

P. O. Address Manassas

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.