

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014230

FILED VS APR 25 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 462 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo, b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Xxxxx St Joseph		Length of stay in 1b xxxx 4 days	c. CITY OR TOWN Amity
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sisters Hosp,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) in town
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Robert Lindsay Burnett			4. DATE OF DEATH Month Day Year 4 12- 60			
--	--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1882	9. AGE (last birthday) 78	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) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Mo,	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	------------------------------------

13a. FATHER'S NAME John Burnett	13b. MOTHER'S MAIDEN NAME Isabel Robertson	14. NAME OF HUSBAND OR WIFE Elizabeth Burnett
---------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 500-362439	17. INFORMANT Address Elizabeth Burnett Amity Mo,
---	------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 7-10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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 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 May 1957 to 4-12-60 and last saw her him alive on 4-11-60. Death occurred at 6 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22. SIGNATURE (Degree or title) J.S. Weiger M.D.	22b. ADDRESS Maysville, Mo	22c. DATE SIGNED 4/14/60
--	----------------------------	--------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-14-60	23c. NAME OF CEMETERY OR CREMATORY Amity	23d. LOCATION (City, town, or county) Amity Mo
--	-------------------	--	--

24. FUNERAL DIRECTOR John Brown	ADDRESS Maysville Mo	25. DATE RECD. BY LOCAL REG. April 18, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
---------------------------------	----------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF J.S. Weiger, M.D. MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. 3933

P. O. Address Maysville Mo

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.