

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-040890

FILED VS NOV 28 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 339 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>			Length of stay in 1b <b>11 yrs</b>		c. CITY OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <del>HOSPITAL OR INSTITUTION</del> <b>516 N. Elson St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>516 N. Elson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNICE L. BURRUS</b>				4. DATE OF DEATH Month Day Year <b>Nov. 24 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIAGE HISTORY</del> Widowed <input checked="" type="checkbox"/> <del>Married</del> <input type="checkbox"/> <del>Single</del> <input type="checkbox"/>		8. DATE OF BIRTH <b>4/29/90</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and state or country) <b>Adair Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>
13a. FATHER'S NAME <b>Caleb Crandall</b>			13b. MOTHER'S MAIDEN NAME <b>Susan Davis</b>			14. NAME OF HUSBAND <del>CRANDALL</del> <b>John R. Burrus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give was or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lorene Smith, Granger, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
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) <b>Arteriosclerotic Heart Disease</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 <b>11-10-60</b> to <b>11-21-60</b> and last saw <sup>her</sup> <del>him</del> alive on <b>11-21-60</b> Death occurred at <b>10:45 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Richard P. Valuck DO.</b>				22b. ADDRESS <b>Laughlin Hosp. Kirksville Mo</b>		22c. DATE SIGNED <b>11-25-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/27/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greensburg</b>		23d. LOCATION (City, town, or county) (State) <b>Greensburg, Knox, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-25-1960</b>		26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>		

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION VALUCK

RICHARD P. VALUCKI, D.O.

**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 *Nova E. Foster*  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Md

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