

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045836

LED VS

JAN 3 1961 139

Registration District No. 4221 Registrar's No. 77

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>HOLT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOLT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MOUND City</b>		Length of stay in 1b <b>70 YEARS</b>	c. CITY OR TOWN <b>MOUND City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>FRED MARION BURKS</b>			4. DATE OF DEATH Month Day Year <b>Dec 28 1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/1887</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRUG STORE</b>	11. BIRTHPLACE (City and state or country) <b>NEBRASKA</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM BURKS</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH ANN MAY</b>		14. NAME OF HUSBAND OR WIFE <b>LUCILLE BURKS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-03-9494</b>		17. INFORMANT Address <b>MRS. Lucille BURKS, MOUND City, 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>Carcinoma Brain</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Lung</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 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>July 2, 6-60</b> to <b>Dec 28-60</b> and last saw <sup>her</sup> him alive on <b>Dec 28-60</b> Death occurred at <b>1-3 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>D. Perry</b> (Degree or title) <b>MD</b>		22b. ADDRESS <b>Mound City Mo.</b>		22c. DATE SIGNED <b>12-29-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/30/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT HOPE</b>		23d. LOCATION (City, town, or county) (State) <b>MOUND City, Mo.</b>
24. FUNERAL DIRECTOR <b>James H. Beauford</b> ADDRESS <b>MOUND City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/29/1960</b>	26. REGISTRAR'S SIGNATURE <b>James H. Beauford</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JAN 4 1961

STATEMENT BY LICENSED EMBALMER

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

*James H. Crawford*

Licensed Embalmer No. 4790

P. O. Address Mound Co

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.