

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		a. STATE Missouri Nebr. b. COUNTY Douglas	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Pacific Hospital		d. STREET ADDRESS (If outside, give location) 1516 Grant	

3. NAME OF DECEASED (Type or print) First **Harold** Middle Last **Burbridge** 4. DATE OF DEATH Month **December** Day **17** Year **1960**

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 3/18/1904	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R. R.	11. BIRTHPLACE (City and state or country) Omaha, Nebraska.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Evelyn Burbridge
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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. Nil.	17. INFORMANT Evelyn Burbridge, 1516 Grant, Omaha, Neb.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Manual abscess caused from fractured upper lobe, Chronic Myocarditis.**

DUE TO (b) **slipped in accident on Interoute Highway in Jefferson Park, South Dakota. True Cause**

DUE TO (c) **and manner of same could not be determined**

INTERVAL BETWEEN ONSET AND DEATH **None on left**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) **Brain Vascular**

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) see above
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20c. TIME OF INJURY Hour **?** a.m. **?** p.m. **?** Month, Day, Year **8x**

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 Omaha, Nebraska
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patrick E. Taylor Coroner (Degree & title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 12-19-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-19-60	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City, town, or county) (State) Omaha, Nebraska.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington,	25. DATE RECD. BY LOCAL REG. DEC 19 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

Obit - Auto accident

MAR 10 1961

JAN 9 1961 SA

MAR 27 1961

JUL 13 1962

NOV 1 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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Benkelley

Licensed Embalmer No. 365

P. O. Address St Louis

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