

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000264

FILED VS. JAN 17 1961 38 Primary Registration District No. 4048 Registrar's No. 10

STATE FILE NUMBER

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rocheport, Mo.</b>		Length of stay in 1b		c. CITY OR TOWN <b>Rocheport, Mo.</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 <b>at home</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kelly</b> Middle <b>Burriss</b> Last <b>Burriss</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-81</b>	
9. AGE (last birthday) <b>79</b>		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) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Rocheport Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>Luther Burriss</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs Sophia Jackson Rocheport Mo</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Mrs Sophia Jackson Rocheport 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>pulmonary edema</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>hypertension</b> Interval between onset and death <b>2 days</b> 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.) <b>Natural</b>			
20c. TIME OF INJURY Hour <b>8 AM</b> Month, Day, Year <b>Jan 4, 1961</b> a.m. p.m.		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>1958</b> to <b>Jan 3, 1961</b> and last saw her <b>live on Jan 3, 1961</b> Death occurred at <b>8 AM Jan 4, 1961</b> in on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Mr. J. Shaw M.D.</b> (Degree or title)				22b. ADDRESS <b>Lee Hospital, Fayette, Mo</b>		22c. DATE SIGNED <b>1-4-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Jan 7 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smiths Care</b>		23d. LOCATION (City, town, or county) (State) <b>Rocheport Mo</b>	
24. FUNERAL DIRECTOR <b>Geoffrey Lewis, Fulton, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>Jan 7 1961</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>	

FEB 7 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 George H. Green  
Licensed Embalmer No. 4720  
P. O. Address Fullon 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.