

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004833

STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 37

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

FILED VS. MAR 8 1961

1. DECEASED'S NAME a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>		Length of stay in 1b <u>3 hrs. 14 min.</u>	c. CITY OR TOWN <u>Weston</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Kansas City Mem. Hosp.</u>		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 <u>Clayton</u> Middle <u>Melvin</u> Last <u>Burrow</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1961</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	9. AGE (last birthday) <u>47</u>
11. BIRTHPLACE (City and state or country) <u>St Clair Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Lewis Burrow</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Rosa Mae Burrow</u>
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 <u>Rosa Mae Burrow, Weston Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Shock</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Laceration &amp; contusion right frontal lobe brain -</u>			
DUE TO (c) <u>Gunshot wound forehead</u>			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Apparently self-inflicted</u>	
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 <u>Pathologist</u> to <u>2-28-61</u> and last saw him alive on <u>2-28-61</u> Death occurred at <u>2:14 PM</u> the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W.R. M. Shee M.D. Dr. OS. Pate</u>		22b. ADDRESS <u>North Kansas City Memorial Hospital North Kansas City, Mo</u>	22c. DATE SIGNED <u>2-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Roscoe Cem</u>	23d. LOCATION (City, town, or county) State <u>Roscoe Mo</u>
24. FUNERAL DIRECTOR <u>Goodrich &amp; Home</u>		25. DATE RECD. BY LOCAL REG. <u>2-28-61</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Audgens</u>

MAR 8 1961

MAR 14 1961

MAR 31 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 Paul J. [Signature]

Licensed Embalmer No. 3190

P. O. Address C. Scoville Me

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.