

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012270
STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 4152 Registrar's No. 16

AMENDED

FILED APR 5 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Stoddard</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty</u> | | Length of stay in 1b | c. CITY OR TOWN <u>Dexter</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Star Route</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Ellsworth</u> Last <u>Burke</u> | | | 4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1961</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>5-2-1904</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care-taker of Country Club</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Club</u> | 9. AGE (last birthday) <u>56</u> |
| 11. BIRTHPLACE (City and state or country) <u>Washington, Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>John Burke</u> | | 13b. MOTHER'S MAIDEN NAME <u>Anna McLaughlin</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Nellie</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | |
| 17. INFORMANT <u>Nellie Burke</u> | | | Address <u>Dexter, 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>Investigation made by coroner and no evidence of foul play found.</u> DUE TO (b) <u>Death due to massive Internal Hemorrhage</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</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 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.) | |
| 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 _____, to _____ and last saw her/him alive on _____ Death occurred at <u>10:15</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Marsh Watkins</u> Coroner | | 22b. ADDRESS <u>Dexter, Mo.</u> | |
| 22c. DATE SIGNED <u>3-28-61</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>3-27-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sadler's Chapel</u> | 23d. LOCATION (City, town, or county) (State) <u>R.F.D.#2, Dexter, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Rainey Funeral Home, Dexter, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>3/31/61</u> | 26. REGISTRAR'S SIGNATURE <u>Velma Jenkins</u> |

JUN 6 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 Mark Walker

Licensed Embalmer No. 4717

P. O. Address Dexter M

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.