

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018259

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 202

FILED JUN 13 1961

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Hannibal</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Elizabeth Hospiya</u>		d. STREET ADDRESS (If outside, give location) <u>4 Forrest Hills</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edgar</u> Last <u>Burson</u>			4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1889</u>
9. AGE (last birthday) <u>71</u>		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) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Wellington, Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Marion S. Burson</u>	
13b. MOTHER'S MAIDEN NAME <u>Mattie Dailey</u>		14. NAME OF HUSBAND OR WIFE <u>Goldie Burson</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>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Bonnie Salyer, 4 Forrest Hills, Hannibal, Mo.</u>		Address	
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>Coronary occlusion, myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign hypertrophy of prostate.</u>			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 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 <u>5/27/61</u> to <u>6/5/61</u> and last saw her/him alive on <u>6/4/61</u>		COUNTY _____ STATE _____	
21. I attended the deceased from _____ Death occurred at _____ 8:25AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. J. Roller, (Print name or title)</u>		22b. ADDRESS <u>2910 St. Mary's Avenue Hannibal, Missouri</u>	
22c. DATE SIGNED <u>6/5/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wellington, Kansas</u>	23d. LOCATION (City, town, or county) (State) <u>Wellington, Kansas</u>
24. FUNERAL DIRECTOR <u>H. M. O'Donnell, Hannibal, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/5/61</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Lillian M. Herman</u>

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 H M O'Connell

Licensed Embalmer No. 3889

P. O. Address Stennibal

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.