SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=021100
STATE FILE NUMBER

AMENDED

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 73

FILED JUL 11 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Howard
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette
Length of stay in 1b: 5-Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sheilds Home
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Chariton
c. CITY OR TOWN Keytesville
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 605 Grand Ave.
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Olive Middle: H. Last: Burns
4. DATE OF DEATH Month: July Day: 6th, Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 2-25-1876
9. AGE (last birthday): 85
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Howard County, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George W. Hocker
13b. MOTHER'S MAIDEN NAME: Ann E. Attebery
14. NAME OF HUSBAND OR WIFE: William H. Burns
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Anna Ruth Stevenson, Glasgow, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 years.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Fractured left hip.
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fall.
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: June 1961
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
20f. CITY, TOWN, OR LOCATION: Keytesville COUNTY: Chariton STATE: Mo
21. I attended the deceased from July 3- 1961, to July 6- 61 and last saw her/him alive on 7-4-61
Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Jm J. Shaw (Degree or title) M.D.
22b. ADDRESS: Fayette Mo.
22c. DATE SIGNED: 7/7/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 9th, 1961
23c. NAME OF CEMETERY OR CREMATORY: City Cemetery
23d. LOCATION (City, town, or county): Keytesville, (State) Mo.
24. FUNERAL DIRECTOR: H. D. Garnett ADDRESS: Keytesville, Mo.
25. DATE RECD. BY LOCAL REG.: 7-7-61
26. REGISTRAR'S SIGNATURE: Katherine Welch

(Licensed Embalmer's Statement on Reverse Side)

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. D. Garnett

Licensed Embalmer No. 3046

P. O. Address Key Teswille

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.