Dr. Burns

MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ARTMENT OF PUBLIC HEALTH AND WELFARE

61-021898

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 230

FILED JUL 5 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal — Length of stay in 1b:
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Levering Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Pike
c. CITY OR TOWN: Frankford — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: Golian
4. DATE OF DEATH: Month 6 Day 19 Year 61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/19/61
9. AGE (last birthday): — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HR: Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - -
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Hannibal, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Andy Golian, Jr.
13b. MOTHER'S MAIDEN NAME: Margaret Pleasure
14. NAME OF HUSBAND OR WIFE: - -
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.:
17. INFORMANT: Andy Golian, Jr. Address: Frankford, 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): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Birth trauma c̄ breech extraction
DUE TO (c):
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-19-61, to 6-19-61 and last saw ~~her~~ him alive on 6-19-61
Death occurred at 1:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Francis R Burns M D
22b. ADDRESS: Hannibal Missouri
22c. DATE SIGNED: 6-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/20/61
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal, Mo.

24. FUNERAL DIRECTOR — ADDRESS: H. M. O'Donnell, Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: 6/27/61
26. REGISTRAR'S SIGNATURE: Dr. E.M. Luche by Lillian M. Norman

(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 M O'Donnell

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.