

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024098

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 700 STATE FILE NUMBER

**FILED JUL 17 1961**

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>3 Yr. 10 Mo</u>	c. CITY OR TOWN <u>Carrollton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph State Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ALONZO</u> Middle <u>FRANCIS</u> Last <u>BURNSIDE</u>	4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1939</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Carroll Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Burnside</u>	13b. MOTHER'S MAIDEN NAME <u>Missouri Audsley</u>	14. NAME OF HUSBAND OR WIFE <u>Viola</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>    </u>	17. INFORMANT <u>Records- St. Hospital, St. Joseph, Mo.</u>	Address <u>    </u>
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18. CAUSE OF DEATH (Enter only one cause by for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Causes - Unattended Death</u>		INTERVAL BETWEEN ONSET AND DEATH <u>    </u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Investigated by the City Health Dept</u>	
DUE TO (c) <u>    </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>    </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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>    </u>
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20c. TIME OF INJURY Hour <u>    </u> a.m. <u>    </u> p.m. <u>    </u>	Month, Day, Year <u>    </u>
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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.) <u>    </u>	20f. CITY, TOWN, OR LOCATION <u>    </u> COUNTY <u>    </u> STATE <u>    </u>
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21. I attended the deceased from      to      and last saw her/him alive on     .  
Death occurred at 5:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert W. Kieber MD Health Dept St Joseph, Mo</u> (Degree or title)	22b. ADDRESS <u>    </u>	22c. DATE SIGNED <u>7-11-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater</u>	23d. LOCATION (City, town, or county) (State) <u>Missouri</u>
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24. FUNERAL DIRECTOR <u>H.O. Sidupaden &amp; Son St Joseph, Mo</u> ADDRESS <u>    </u>	25. DATE RECD. BY LOCAL REG. <u>July 12, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Miss Clark Goodell</u>
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(Licensed Embalmer's Statement on Reverse Side)

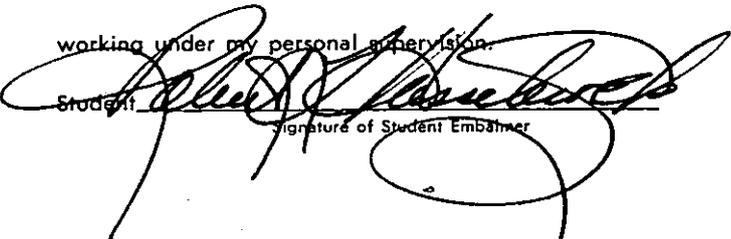
DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 R.W. Kieber, M.D. Medical Certification

**STATEMENT BY LICENSED EMBALMER**

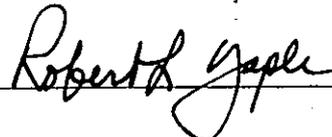
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by Robert L. Hassebroek, Student Embalmer No. 617

working under my personal supervision.

Student

  
Signature of Student Embalmer

Signed



Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.