

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027988

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 375 Primary Registration District No. 4480 Registrar's No. 14

AMENDED
FILED AUG 14 1961

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH: a. COUNTY <u>Schuyler</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Schuyler</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greentop</u> | | Length of stay in 1b | c. CITY OR TOWN <u>Greentop</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT H. BURKHART</u> | | | 4. DATE OF DEATH Month Day Year <u>Aug. 9 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>2-15-1877</u> | 9. AGE (last birthday) <u>84</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Greentop Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>CARL BURKHART</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Eva Burkhart</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 17. INFORMANT <u>Nerwitta B. Utter</u> Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Central Thrombus</u> | | | | | <u>1 day</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Head Failure</u> | | | | | <u>5 months</u> |
| DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | <u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenocarcinoma 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 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.) | | |
| 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 <u>8/23/50</u> , to <u>8/9/61</u> and last saw him alive on <u>8/8/61</u> Death occurred at <u>4:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Decede or next of kin) <u>Edward M. Roberts, M.D.</u> | | | 22b. ADDRESS <u>Queen City, Mo.</u> | | 22c. DATE SIGNED <u>8/9/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>8-11-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Queen City Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Queen City Mo.</u> |
| 24. FUNERAL DIRECTOR <u>DODDLEY FUNERAL HOME</u> | | ADDRESS <u>Queen City</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-10-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Florence Shepherd</u> |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF

DOCUMENT

MS AUG 24 1961

AUG 17 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 Jack I. Goolby
Licensed Embalmer No. 4619

P. O. Address Queen City, 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.