

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036220

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 61 Primary Registration District No. 4102 Registrar's No. 22

DECEASED ED OCT 17 1961

1. PLACE OF DEATH a. COUNTY <u>Cedar</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u>		c. CITY OR TOWN <u>El Dorado Springs</u>	
Length of stay in 1b		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>Cedar Co. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. 4</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Vada</u> Middle <u>Kinyon</u> Last <u>Kinyon</u>			4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1961</u>			
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5. SEX <u>Female</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>10-11-1889</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Clair Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James O. Burch</u>	13b. MOTHER'S MAIDEN NAME <u>Maggie Hurt</u>	14. NAME OF HUSBAND OR WIFE <u>--</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>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Elton Burch, El Dorado Spgs. Mo.</u>	Address
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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>Cerebral vascular accident</u> <u>cerebral thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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. <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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION <u>El Dorado Springs, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>August 1961</u> to <u>Oct. 11, 1961</u> and last saw her <u>10/11/61</u> alive on <u>10/11/61</u>

Death occurred at <u>4:05 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Robert L. Magee M.D.</u>	(Degree or title)	22b. ADDRESS <u>El Dorado Springs, Mo.</u>	22c. DATE SIGNED <u>10-13-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-15-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>El Dorado Spgs. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>El Dorado Springs, Mo.</u>
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24. FUNERAL DIRECTOR <u>Gwinn-Carothers, El Dorado Spgs., Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-14-61</u>	26. REGISTRAR'S SIGNATURE <u>Dave Gessert</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Floyd E. Caruthers

Licensed Embalmer No. 4419

P. O. Address E. Donado Spr

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.