

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-043805

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 315

AMENDED

FILED JAN 2 1962

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

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Burton</u> Last <u>Burton</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>61</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1880</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Months <u></u> Days <u></u> 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>unk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>New Bloomfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>unk</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>unk</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>unk</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>State Hospital No. 1, Fulton, Mo.</u>
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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>ASHD - Decompensated</u> DUE TO (b) <u>Cerebral Arterio Sclerosis</u> DUE TO (c) <u>Gen Arterio sclerosis</u>		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 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.) <u>State Hospital No. 1</u>	20f. CITY, TOWN, OR LOCATION <u>Fulton, Mo.</u>	COUNTY	STATE
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21. X attended the deceased from 5:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
Death occurred at 5:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William J. Tarver M.D.</u>	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>12/30/61</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Jan. 1, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Int. Corner</u>	23d. LOCATION (City, town, or county) <u>Callaway</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Chen Dupin</u>	ADDRESS <u>Fulton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 30-1961</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

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 *Gene C. Yarns*

Licensed Embalmer No. 5092

P. O. Address Fulton, 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.