

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-014970

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 139 Primary Registration District No. 3023 Registrar's No. 106

**FILED MAY 7 1962**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Henry</u>	b. CITY (If outside corporate limits, also TOWNSHIP only) <u>Clinton</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Henry</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Moores Rest Home</u>		d. STREET ADDRESS (If outside, give location)	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb OR TOWN <u>1-5-61</u>		c. CITY OR TOWN <u>Clinton</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>SAMUEL</u>	Middle <u>D</u>	Last <u>BURNSIDES</u>	4. DATE OF DEATH	Month <u>4</u>	Day <u>29</u>	Year <u>1962</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>W</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>1-20-1890</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Henry Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jas. Burnside</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Fletcher</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Robert Burnside</u>	Address <u>Clinton Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	<u>Coronary heart failure</u>	<u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis of Coronaries</u>	<u>5 years</u>
	DUE TO (c) <u>Generalized arteriosclerosis</u>	<u>20 years</u>

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
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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 a.m. p.m.	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	COUNTY	STATE
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21. I attended the deceased from 1947 to 1962 and last saw him alive on 4-26-62  
Death occurred at 4:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Samuel D. Smith MD</u>	22b. ADDRESS <u>Clinton, Missouri</u>	22c. DATE SIGNED <u>4-30-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-2-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Henry Co. Missouri</u>
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24. FUNERAL DIRECTOR <u>F.L. SCHABERG</u>	ADDRESS <u>Clinton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 1, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Hildred Bigum</u>
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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 F. L. Scholberg

Licensed Embalmer No. 4513

P. O. Address Clinton 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.

Bernard Steinwald  
5/1/62  
M.B.