

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-015130

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2308

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAY 14 1962**

VS 300  
Rev. 4/59  
  
10971-  
20771  
  
3  
4 1  
5 1  
6  
7 0  
8 2  
9 200.1  
10  
11  
12 66-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John H. Wheeler

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>8 Das.</b>	c. CITY OR TOWN <b>Slater</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke Hospt.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Slater, Mo.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Deede</b> Middle <b>Burn</b> Last <b>Burr</b>			4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-13</b>
9. AGE (last birthday) <b>48</b>		IF UNDER 1 YEAR Months <b>48</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Odessa, Mo.</b>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <b>Leyburn Armstrong</b>	13b. MOTHER'S MAIDEN NAME <b>Bennie B. Boone</b>
14. NAME OF HUSBAND OR WIFE <b>Donald D. Burr</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>-</b>
17. INFORMANT <b>Donlad D. Burr, Slater, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma - Systemic</b>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____			
DUE TO (c) _____			
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 checked="" 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 <b>4-17-62</b> to <b>4-26-62</b> and last saw her alive on <b>4-26-62</b>		Death occurred at _____ <b>6</b> P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>M.D. 4320 Wornall Road, K. C. Mo.</b>	22c. DATE SIGNED <b>4-27-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Apr. 27, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Odessa, Mo.</b>
24. FUNERAL DIRECTOR <b>Husman-Sparks, Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-27-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

MAY 16 1962

**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

*William T. Sparks*

Licensed Embalmer No.

*4431*

P. O. Address

*Odessa, 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.