

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-045720

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 369 Primary Registration District No. 6253 Registrar's No. 7

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 12 1962	
1. PLACE OF DEATH	
a. COUNTY <u>Wayne</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Williams Township</u>	a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u>
Length of stay in 1b	c. CITY OR TOWN <u>Williamsville</u> 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>1 Mi West of Williamsville</u>	d. STREET ADDRESS (If outside, give location) <u>Highway A West</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	
First <u>Lydia</u> Middle <u>Angeline</u> Last <u>Burkett</u>	4. DATE OF DEATH
5. SEX <u>Female</u>	8. DATE OF BIRTH <u>12-17-1918</u>
6. COLOR OR RACE <u>White</u>	9. AGE (last birthday) <u>83</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY
11a. FATHER'S NAME <u>James Irby</u>	11b. MOTHER'S MAIDEN NAME <u>Martha Edwards</u>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	12b. SOCIAL SECURITY NO.
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME
14a. NAME OF HUSBAND OR WIFE <u>James M. Burkett (deceased)</u>	14b. NAME OF HUSBAND OR WIFE
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>Mrs Lottie Dockett Williamsville Mo</u>	
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>Bronchial Pneumonia, one week</u>	
DUE TO (b) <u>Hypertension, 2 years.</u>	
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 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.)	
20c. TIME OF INJURY Hour _____ 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>Aug. 4, 1954</u> to <u>Nov. 24, 1962</u> and last saw her/him alive on <u>May 20, 1962</u>	
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Physician or other qualified person) <u>W. L. Brandon, M. D.</u>	22b. ADDRESS <u>1124 N. Main, Poplar Bluff</u>
22c. DATE SIGNED <u>12/1/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-28-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Miller Creek Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Wayne Co Mo.</u>
24. FUNERAL DIRECTOR <u>William Coder Fredmont Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/2/62</u>
26. REGISTRAR'S SIGNATURE <u>Sheila Louder</u>	

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

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 Coder Funeral Home, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Coker

Licensed Embalmer No. 3723

P. O. Address Bedmont 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.