

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13452

State File No.

 BIRTH NO. _____ REG. DIST. NO. 295 PRIMARY REG. DIST. NO. 6015 Registrar's No. 790

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Mo</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural - Salt Spring</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Higbee</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant View Nursing Home</u>		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>William Peter</u> b. (Middle) <u>Burkey</u> c. (Last) <u>Burkey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 4 1949</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8/16/1863</u>
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Boone Co. Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Arthur Burkey</u>	
13b. MOTHER'S MAIDEN NAME <u>Josephine Under</u>		14. NAME OF HUSBAND OR WIFE <u>Betty Robertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Jeff Burkey</u>		ADDRESS <u>Seaside</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial degeneration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility and</u> DUE TO (c) <u>Coronary artery disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile dementia, possibly due to cerebral sclerosis.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1948</u> , to <u>Apr. 4, 1949</u> , that I last saw the deceased alive on <u>Apr. 1, 1949</u> , and that death occurred at <u>8 a. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Des. M. Enelman</u> (Degree or title)		23b. ADDRESS <u>D.O. 2 Keintsville, Mo</u>	
23c. DATE SIGNED <u>4/19/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		24b. DATE <u>April 14/49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Holy Hope</u>		24d. LOCATION (City, town, or county) (State) <u>Monticello Mo</u>	
DATE REC'D BY LOCAL REG. <u>May 5-1949</u>		REGISTRAR'S SIGNATURE <u>W.A. Barnhart</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred A Thompson</u>		ADDRESS <u>Madison</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

RECEIVED

District Health Officer No. 10

District File Number 5-49-85

Date Filed MAY 11 1949

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.

Signed _____
Student Embalmer

Signed Ms. Leda A. Thompson

Licensed Embalmer No. 2252

P. O. Address Washington Md

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 this body is not embalmed, fact should be so stated above.