WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Sullivan

Township ~~Bowman~~

or

Village ~~Haley City~~

or

~~City~~ Humphreys P.O. (No. ..... St.; ..... Ward)

Registration District No. 851 File No. 28273

Primary Registration District No. 4517 Registered No. 15

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James M Burbridge

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH ..... (Month) ..... (Day), 1845 (Year)

AGE Record of A.F.& A.M. 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Tanner & Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) Weston, W. Va.

PARENTS

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Alexander, Sec. A.F.& A.M.

(ADDRESS) Humphreys, Mo.

Filed 8-21, 1914. H. A. Allen Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

DATE OF DEATH Aug (Month) 20 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1912, to Aug 20, 1914, that I last saw him alive on Aug 19, 1914, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

137 / 130 / 1336 / 119

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (SECONDARY) Chronic Suppurative Prostatitis and Suppression of Urine

(Duration) x yrs. x mos. x ds.

(Signed) M. L. Hanning M. D.

Aug 20, 1914 (Address) Humphreys Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL Humphreys Cemetery

DATE OF BURIAL Aug 21, 1914

UNDERTAKER J. F. Fertig

ADDRESS Humphreys, Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS