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 Knox

Township _____ Registration District No. 441 File No. 25105

or

Village _____ Primary Registration District No. 4259 Registered No. 14

or

City Edina (NO. _____ St.: _____ Ward)

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

FULL NAME Thomas Burns

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: May (Month) 17 (Day), 1829 (Year)

AGE: 86 yrs. 1 mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Co. Waterford, Ireland

PARENTS
NAME OF FATHER: James Burns
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland
MAIDEN NAME OF MOTHER: Margaret Griffin
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos O'Donnell

(ADDRESS) Edina, Mo

Filed Aug 10, 1915 H J Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 17th (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 16, 1915, to June 17, 1915, that I last saw him alive on June 16, 1915, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Single)

109 lb

(Duration) 9 yrs. 2 mos. 3 ds.

Contributory (SECONDARY) _____

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

(Signed) Geo S Brown M. D.

8/19, 1915 (Address) Edina 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 6 yrs. ___ mos. ___ ds. In the State 6 yrs. ___ mos. ___ ds.

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

Former or usual residence Quincy, Ill

PLACE OF BURIAL OR REMOVAL: Quincy Ill

DATE OF BURIAL: June 19, 1915

UNDERTAKER: Kriegshauser Bros

ADDRESS: Edina Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 _____

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 June (Month) 17 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 16, 1915, to June 17, 1915, that I last saw him alive on June 16, 1915, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Senile)

_____ (Duration) _____ yrs. _____ mos. 3 ds.

Contributory (SECONDARY) _____

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

(Signed) Scott Brown M. D.

_____, 191__ (Address) Edina 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	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS

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.