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 Henry

Township ~~Windsor~~ or Village or City Windsor (NO. St.; Ward)

Registration District No. 14

Primary Registration District No. 4211

File No. 10101

Registered No. 12

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

FULL NAME Robt. S. Burcham

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Mal	Whit	Married

DATE OF BIRTH Oct. (Month) 24 (Day), 1851 (Year)

AGE 65 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

BIRTHPLACE (City or town, State or foreign country) Otterville Mo

PARENTS

NAME OF FATHER Ruben Burcham

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

MAIDEN NAME OF MOTHER Mary Jenkins

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt. Burcham Jr.

(ADDRESS) Windsor Mo.

Filed Mch 22 1917 W. B. Henning REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 21 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 20, 1916, to Mar. 21, 1917, that I last saw h~~im~~ alive on Mar. 21, 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

39 / 46A

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

8

(Signed) T. A. Blackmore M. D.

Mar. 22, 1917 (Address) Windsor 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 Windsor Mo.

DATE OF BURIAL March 22 1917

UNDERTAKER W. E. Huston

ADDRESS Windsor 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.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., *1*.....
(Month) (Day) (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

....., *191*.....
(Month) (Day) (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

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

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