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

4437

1. PLACE OF DEATH

County: Macon — Registration District No.: 576 — File No.:

Township: Lyda — Primary Registration District No.: 5700 — Registered No.:

City: ~~Atlanta Mo~~ (No. ..... St. ..... Ward)

2. FULL NAME Jane Wright Burnes

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Cap. Burnes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1833

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	88			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired from Farm

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: I Burnes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

12. MAIDEN NAME OF MOTHER: Elizabeth Baily

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Va

14. INFORMANT: Mrs Allie Lapoint
(Address) Atlanta Mo

15. FILED Feb 21, 1921 J M Hollenbeston, REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 1921

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 —, 1921, to Feb - 19 —, 1921, that I last saw her alive on Feb - 19 —, 1921, and that death occurred, on the date stated above, at 6.30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Toxic Jaundice 126

12-48

1270

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cholelithiasis - Common - Duct Obstruction (duration) ..... yrs. ..... mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ✓

DID AN OPERATION PRECEDE DEATH? No. DATE OF ✓

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) A L Cambre, M. D

, 19 (Address) Atlanta Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Tabor	2-20-1920
20. UNDERTAKER	**ADDRESS**
H M Goodding	Atlanta Mo

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.

[illegible], WITH UNFADING INK—THIS IS A PERMANENT RECORD

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred . . yrs. . mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.