

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

Do not use this space.

29622



1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township St Joseph Primary Registration District No. 1001
 City St Joseph (No. State Hospital # 2) St. _____ (Ward) _____
 2. FULL NAME Frank Burton
 (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 3 yrs. mos. ____ da. How long in U.S., if of foreign birth? yrs. mos. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Not Known (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/19/1857
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 4 2
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Janitor
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER George Burton
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Va
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT State Hosp # 2 Record
 (Address) St Joseph

15. FILED 25 1927
John B. Galt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2. 16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/21/27 19
 17. I HEREBY CERTIFY, That I attended deceased from 7/15/25, 19____, to 10/21/27, 19____, (that I last saw h. _____ alive on 10/20/27 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of penis
51F
11%.

(duration) _____ yrs. mos. ____ da.
 CONTRIBUTORY Senile Dementia
 (SECONDARY) (duration) _____ yrs. mos. ____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF BIRTH? USA

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) J. H. Rameier, M. D.
 , 19____ (Address) State Hosp # 2 St Joseph

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kubsville Mo. DATE OF BURIAL 10/25 1927

20. UNDERTAKER B F Graves JTM ADDRESS 13097428

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.

