

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

Do not use this space.

30232

**1. PLACE OF DEATH**

County Greene Registration District No. 318  
 Township Springfield Registration District No. 200  
 City Springfield (No. Ellis Park, Mo.) St. Mo. Ward

File No. \_\_\_\_\_  
 Registered No. 667  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Ellis Park 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
35 10 13

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work House wife  
 (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.

10. NAME Marshall Burriss

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

12. MAIDEN NAME OF MOTHER Nettie Burriss

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

14. INFORMANT (Address) A. F. Bolding  
Ellis Park, Mo.

15. FILED 9-26-28 Ol. Horst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 935 Sept 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1928, to Sept 24, 1928, that I last saw him alive on Sept 22, 1928, and that death occurred, on the date stated above, at about 9:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Exophthalmic Goiter - 40 or 5 years duration  
Asthma - 4 weeks  
Full term pregnancy

CONTRIBUTORY (SECONDARY) W. A. (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

19. WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Ray D. Callaway, M.D.

, 19 (Address) Springfield, 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.

19. PLACE OF BURIAL, CREMATOR, OR REMOVAL DATE OF BURIAL  
Oakland Cem Co 9-26-28

20. UNDERTAKER ADDRESS  
W. L. Stame Springfield, Mo.

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.

RECORD

