

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

Do not use this space.

2343

1. PLACE OF DEATH

County Linn
Township
City Marceline

Registration District No. 502
Primary Registration District No. 4325

File No. _____
Registered No. 1
St. _____ Ward _____

2. FULL NAME

Derrison Dornau Burch

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Stella Paucost Burch

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

June 10 1840

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>83</u>	<u>6</u>	<u>22</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Ripley
(STATE OR COUNTRY) ny.

10. NAME OF FATHER

Rastus Burch

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Rock Hill
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

" "

14.

INFORMANT Paul Burch
(Address) Marceline mo

15.

FILED 1/3 1928 Ch. Putman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 19 28

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928, to Jan 2, 1928
that I last saw him alive on Jan 2, 1928, and that death occurred, on the date stated above, at 5:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Pneumonia
109A (duration) yrs. mos. da.
CONTRIBUTORY Suppurative (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
At home
IF NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? P. L. Tuberc.
(Signed) P. L. Tuberc., M. D.
, 19 (Address) Marceline

*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 Mr. Oliver DATE OF BURIAL Jan 3 19 28

20. UNDERTAKER Geo M. Laughlin ADDRESS Marceline 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.

22 929
88-6-22
2
31
31

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Linn

Registration District No. 572

File No.

Township

Primary Registration District No. 4305

Registered No.

City Marceline (No.)

St. Ward)

2. FULL NAME

Dennison Jernan Burch

(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

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M.

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

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

June 10 - 1840

7. AGE

88 YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

6 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

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 3/14, 1929 Wla Putnam REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY That I attended deceased from

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:

CONTRIBUTORY (SECONDARY)

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.

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

19

20. UNDERTAKER

ADDRESS

REG. RARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY AR. COMPLETE AS PRESCRIBED BY LAW
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-2343