

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. 3109 Senica Street)

File No. 9583
Registered No. 285
St. _____ Ward _____

2. FULL NAME Mary Isabelle Burns

(a) Residence. No. 3109 Senica Street St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 M.M. Burns

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12, 1851

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
77 7 20 36

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) Emmetsburg
(STATE OR COUNTRY) Maryland

10. NAME OF FATHER Mathias Martin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Maryland
12. MAIDEN NAME OF MOTHER Sally Caldwell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Maryland

14. INFORMANT Geo. L. Burns
(Address) 3107 Senica Street

15. FILED 1929 REGISTRAR John L. [Signature]

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1929 to Mar 2 1929, and that I last saw her alive on Mar 2 1929, and that death occurred, on the date stated above, at 9-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho pneumonia
33c
10-10

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Chronic myocarditis
(SECONDARY) 13

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

18. WHERE WAS DISEASE CONTRACTED 9100
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS Cholelith
(Signed) Dr. [Signature] M. D.

Mar. 4, 19 29 (Address) St. Joseph, 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, CREMATION, OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL Mar. 5 19 29

20. UNDERTAKER H. B. [Signature] ADDRESS 1802 Union St.

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.

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2
2

11
23
1929

