

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

Do not use this space.

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1. PLACE OF DEATH

County Wayne
Township St. Francis
City St. Francis (No. _____)

Registration District No. 890
Primary Registration District No. 6188

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

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 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 Walter Burch

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
58 9 16

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER L. Dure

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

12. MAIDEN NAME OF MOTHER M. Sheard

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

14. INFORMANT (Address) _____

15. FILED 7/6, 1929 Templeton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
apoplexy

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

CONTRIBUTORY (SECONDARY) 74 @ (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) James B. L...
, 19____ (Address) Carroll

*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.

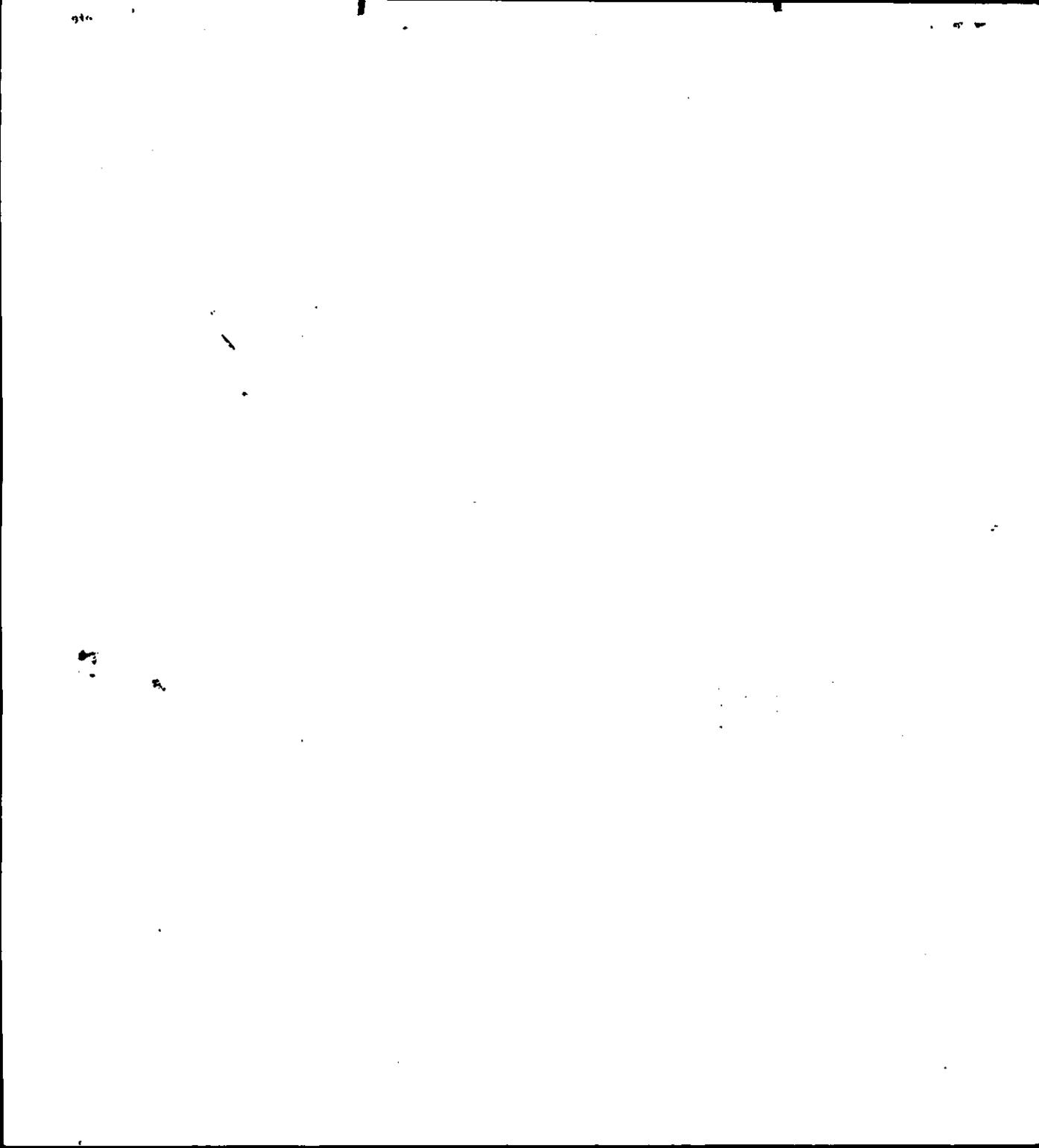
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Silva Cell DATE OF BURIAL 6/21 1929

20. UNDERTAKER Yates and Co Piedmont ADDRESS 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.

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1929



**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 Wayne
Township St. Francis
City (No. _____) (St. _____ Ward)

Registration District No. 890
Primary Registration District No. 6188

File No. _____
Registered No. _____

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 F 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) Sept. 4 - 1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>58</u>	<u>9</u>	<u>16</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
(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 E. B. Leach
(Address) Redwood, Mo.

15. FILED 7/6, 1929 G. E. Campbell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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.

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

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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