

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

Do not use this space.

1699

1. PLACE OF DEATH  
 County Laclede Registration District No. 451  
 Township Eldredge Primary Registration District No. 5616  
 City (No. ....) St. .... Ward)

2. FULL NAME Roy W. Burns  
 (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) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28 1907  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
23 5 18

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

9. BIRTHPLACE (CITY OR TOWN) Laclede Co.  
 (STATE OR COUNTRY)

PARENTS  
 10. NAME OF FATHER Chas. Burns  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Camden Co.  
 12. MAIDEN NAME OF MOTHER Effie Miller  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co.

14. INFORMANT Chas. Smith  
 (Address) Dave Mo.

15. FILED Jan 30 1930 Emmy Byrd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 25 1930  
 17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 24, 1930 that I last saw h. alive on Jan 24, 1930 and that death occurred, on the date stated above, at 12:06 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

1. Myocardial infarct  
 (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) none  
 (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 (duration) .... yrs. .... mos. .... ds.  
 NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS Physical Section  
 (Signed) E. G. Johnson, M. D.  
 , 19 (Address) Dr. J. W. Miller

\*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 Zion Cem. DATE OF BURIAL 1/26 1930

20. UNDERTAKER Palmer ADDRESS Lebanon Mo.

11

**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 Laclede  
Township Eldredge  
City..... (No. ...., St. ...., Ward)

Registration District No. 451  
Primary Registration District No. 3616

File No.....  
Registered No.....

**2. FULL NAME**

Roy W. Burns

(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) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28-1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
X 22 X 5 X 27 X

**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 Jan 30 19 Emma Bjord REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1930

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

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

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

SUPPLEMENTARY

6691-5