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

Do not use this space.

8737

File No.

Registered No. 1115

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Blue — Primary Registration District No. 1002

City Leeds (No. Leeds Hospital St. Ward)

2. FULL NAME Burris, Allen

(a) Residence. No. 537 Clarmont St., 9 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	negro	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5 1886

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
43		9	6	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Burris, Miller

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

12. MAIDEN NAME OF MOTHER Hamilton Alice

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

14. INFORMANT T B Hospital
(Address) Leeds Mo

15. FILED 3/13, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to March 11, 1930 that I last saw him alive on March 11, 1930 and that death occurred, on the date stated above, at 3 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pneumonic Phthisis

23A

31 (duration) 0 yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) None (duration) — yrs. — mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory

(Signed) Edwin Lee, M. D.

Mar 13, 1930 (Address) 1830 Vine St K.C. 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	DATE OF BURIAL
Highland Cemetery	3-14-30 19
20. UNDERTAKER	**ADDRESS**
Flynn + Greenstreet	K C 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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1930-3-11
1886-6-6
43-9-5