

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

Do not use this space.

13059

1. PLACE OF DEATH

County ADAIR

Registration District No. 4

Township Benton

Primary Registration District No. 5-005

City B R KIRKSVILLE MO (No. _____)

File No. _____

Registered No. 83

St. _____ Ward _____

2. FULL NAME NANCIE ANNIE BURESS

(a) Residence. No. S W OF KIRKSVILLE MO Ward. _____

(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

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

W A BURESS

6. DATE OF BIRTH (MONTH, DAY AND YEAR) MARCH 1 1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

55

1

29

8. OCCUPATION OF DECEASED

house wife

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) ADAIR CO MO

10. NAME OF FATHER

A C HALL

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) ADAIR CO MO

12. MAIDEN NAME OF MOTHER JANE CAMPBELL

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) ADAIR CO MO

14.

INFORMANT

(Address)

W A BURESS
KIRKSVILLE MO

15.

FILED

5/30 1931

Mrs C H Becker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-29 1931

17.

I HEREBY CERTIFY, That I attended deceased from Oct 27 1930, to April 29 1931 that I last saw him alive on April 25 1931 and that death occurred, on the date stated above, at 1145 P

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
131 apoplexy
92 R

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Hypertension - Nephritis
(SECONDARY)

(duration) 3 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)

Ralph O. Strickler, M. D.
19 _____ (Address) Kirksville, 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

SALSBERRY CEMETERY

DATE OF BURIAL

5 1 1931

20. UNDERTAKER

Wagon & Wagon

ADDRESS

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.

MAY 24 1931

62

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 10, 1962

REPORT

OF THE

COMMISSIONERS