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

Do not use this space.

31282

1. PLACE OF DEATH

County: Jackson — Registration District No.: 3 0 9 — File No.:

Township: Kaw — Primary Registration District No.: — Registered No.: 3 7 9

City: K.C. Mo (No. ..... St. Joseph Hospital St. ..... Ward)

2. FULL NAME Dr. S. Grover Burnett 6

(a) Residence. No. Lucerne Hotel, K.C. Mo St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 48 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	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR WIFE OF~~ Mrs. Florence Burnett

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-3-1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	69	3	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician
(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) Indiana

PARENTS

10. NAME OF FATHER Don't Know

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

12. MAIDEN NAME OF MOTHER Don't Know

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

14. INFORMANT Mrs. Florence L. Burnett
(Address) Lucerne Hotel K.C. Mo

15. FILED 9/13, 31 M. M. Lemmon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-11-31 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 19 31, to Sept 11 19 31, that I last saw him alive on Sept 10 19 31, and that death occurred, on the date stated above, at 10/15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis
acute cardiac dilitation
131
9 B (duration) yrs. 4 mos. 10 ds.

CONTRIBUTORY (SECONDARY) 131 (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? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy findings
(Signed) C. C. Gilliam M. D.
9/11, 19 31 (Address) 1210 Gillis Bldg.

*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
Mount Moriah	9-14 19 31
20. UNDERTAKER	**ADDRESS**
Freeman Mortuary	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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD