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

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.

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

SEP 20 1934

Do not use this space.

29210

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. [illegible]

Township Kansas — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. KC General Hosp. St. ..... Ward)

2. FULL NAME Thomas B. Burton

(a) Residence, No. 4720 E 9th St., ... Ward. (If nonresident, give city or town and State)
(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.

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: Single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 5-23-1855

7. AGE: YEARS 79 — MONTHS 2 — DAYS 12 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Labor
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Linn Creek Mo

FATHER

13. NAME: Burfman Burton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

MOTHER

15. MAIDEN NAME: Isabelle Cassidy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ill.

17. INFORMANT (ADDRESS): Michael Burton 4720 E 9th

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mound Grove DATE 8-6, 1934

19. UNDERTAKER (ADDRESS): C. D. Carson Undo Co. Spring & Lexington - Indep. Mo.

20. FILED 8-6, 1934 M M Crowe asst Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 8-4, 1934

22. I HEREBY CERTIFY, That I attended deceased from 7-26, 1934 to 8-4, 1934

I last saw him alive on 8-3, 1934 Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

Senility; Arteriosclerosis generalized
107A
97
102

Date of onset

Other contributory causes of importance: Hypostatic Pneumonia

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) G. F. De Maria, M. D.

(Address) Asst Supt KC Gen Hosp. KC Mo.

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.
3623

Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Thomas B. Burton

Who died at _____ on May 4 - 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, ~~married, widowed or divorced~~: _____

Date of birth _____ Age: Years 79 Months 2 Days 12

Occupation: (a) Trade, profession, or particular kind of work done, as spinner; sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Generalized Arteriosclerosis

Birthplace of father (State or country) Bronchitis

Birthplace of mother (State or country) Hypostatic pneumonia

Principal cause of death: _____

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician Dr. P. F. De Maria

Address of physician Asst Supt Gen. Hosp.

Signature of Registrar M. M. Crowe

Date filed 8/6/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

Reg. Dist. No.

Primary Reg. Dist. No.

5-29210