

MAY 19 1937

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

Do not use this space. +

1. PLACE OF DEATH

County CooperRegistration District No. 218File No. 16144Township BoonvillePrimary Registration District No. 3013Registered No. 129City Boonville (No. St Joseph Hospital St. Blackwater Mo. Ward)2. FULL NAME William O. Burge(a) Residence, No. Blackwater Mo. St. Blackwater Mo. Ward. Blackwater Mo.
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jennie Burge6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 29-18617. AGE YEARS 76 MONTHS 2 DAYS 11 If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farm10. Date deceased last worked at this occupation (month and year) Apr 7-1937 11. Total time (years) spent in this occupation 112. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo13. NAME Oscar F Burge14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky15. MAIDEN NAME Elizabeth Miller16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo17. INFORMANT Robert Burge (ADDRESS) Boonville, Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Old Danville DATE Apr 11-193719. UNDERTAKER Goodman & Belle (ADDRESS) Boonville, Mo20. FILED Apr 16, 1937 St Joseph Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 9th 193722. I HEREBY CERTIFY, That I attended deceased from April 7-1937 to April 9-1937I last saw him alive on April 9-1937 Death is said to have occurred on the date stated above, at 5 P. m.

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

Renal SepticemiaDate of onset 4-7-37Other contributory causes of importance: NoName of operation Amputation Throat Date of 4-8-37What test confirmed diagnosis? Microscopy 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? No

If so, specify _____

(Signed) W. J. Jones M. D.(Address) Blackwater, Mo

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Chapier Registration District No. 218
Township _____ Primary Registration District No. 3015-
City Boonville (No. _____, _____ St. _____ Ward _____)

File No. 16144
Registered No. _____

2. FULL NAME William O. Burge

(a) Residence, No. _____ St. _____ Ward _____
(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.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>76</u>	MONTHS <u>2</u>
	DAYS <u>11</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 9 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Acute Septicemia
Fractured ribs
degenerative
N.M.O.

Other contributory causes of importance:

h

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. UNDERTAKER (ADDRESS)

20. FILED June 19 1937 B. Hooper Registrar

Name of operation _____ Date of _____

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

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) Wm G. Abney, M. D.
(Address) Blackwater, Mo

SUPPLEMENTARY

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

5-16144