

A review 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.

Wif  
1 JUL 3 0 1937

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

Do not use this space.

24247

1. PLACE OF DEATH  
 County Mason Registration District No. 547  
 Township Mason Primary Registration District No. 3079  
 City Hannibal (No. 827 S. Arch) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Eleanor W. Burgess  
 (a) Residence, No. 827 S. Arch St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Burgess

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12 - 1847

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<u>90</u>	<u>-</u>	<u>-</u>	<u>12</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

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) Ill

13. NAME James Watson

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

15. MAIDEN NAME Elysis Burgess

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

17. INFORMANT Mr. William P. Burgess  
(ADDRESS) 827 S. Arch St

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Mt Olenet Cem DATE May - 26<sup>th</sup> 1937

19. UNDERTAKER James O'Donnell  
(ADDRESS) 1111 Commercial

20. FILED 6/8 1937 H. C. Fisher  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May - 24<sup>th</sup> 1937

22. I HEREBY CERTIFY, That I attended deceased from on May 19, 1937,  
 I last saw her alive on May 19, 1937 Death is said to have occurred on the date stated above, at 2:45 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Hemorrhage on the brain Date of onset not known

Other contributory causes of importance:  
Arteriosclerosis

Name of operation none 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) J. A. Chilton, M. D.  
 (Address) 500 Broadway  
Hannibal, Mo

