

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

29487
Do not use this space.

REC'D SEP 16 1938

1. PLACE OF DEATH

(a) County MILLER Registration District No. 561
 (b) Township Saline Primary Registration District No. 4330 Registered No. 60
 (c) City FLON (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

Effie M Burris

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 OR (OR) WIFE LEVI WESLEY BURRIS
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT. 22 1892
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 11 12
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HANDS WIFE
 9. Industry or business in which work was done, as 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) 9-4, 1938
 22. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1938 to Sept 4, 1938
 I last saw her alive on 9-4, 1938 Death is said to have occurred on the date stated above, at 2:00 p.m.
 The principal cause of death and related causes of importance were as follows:

Peritonitis
 Date of onset 9-2

Other contributory causes of importance:
Ruptured Gall Bladder 9-13

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MILLER Co. Mo
 13. NAME John Jolly
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MILLER Co Mo
 15. MAIDEN NAME MARY PARMER
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MILLER Co Mo
 17. INFORMANT Mr. LEVI WESLEY BURRIS (ADDRESS) Kansas City Kansas
 18. BURIAL, CREMATION, OR REMOVAL PLACE KANSAS CITY, MO. DATE SEPT 3
 19. FUNERAL DIRECTOR Keith M Kaye (ADDRESS) 4409 22E
 20. FILED 9-4, 1938 Belle Haynes Local Registrar. 495

Name of operation none Date of _____
 What test confirmed diagnosis? clinical 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) E. S. Skilton, M. D.
 (Address) Edison

127

STATEMENT BY LICENSED EMBALMER

I, Keith McKays, Licensed Embalmer No. 3998

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed Keith McKays
Licensed Embalmer No. 3998

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
BUREAU OF HEALTH SERVICES
100 N. BROAD ST., 10TH FLOOR
PHILADELPHIA, PA. 19107
TEL: 215-856-6100
FAX: 215-856-6101
WWW: www.dhs.pa.gov

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29487
Do not use this space.

1. PLACE OF DEATH

(a) County *in iller* Registration District No. *561*
(b) Township..... Primary Registration District No. *4330*
(c) City *Eldon* (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *Effie M. Burris* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *M*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9 - 4 - 1938*

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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 11 12

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

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

peritonitis
Date of onset

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

Other contributory causes of importance:
Ruptured gall bladder

13. NAME

Probably due to

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

small stones 833

15. MAIDEN NAME

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

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

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

17. INFORMANT (ADDRESS)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

18. BURIAL, CREMATION, OR REMOVAL

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (ADDRESS)

Manner of injury..... Nature of injury.....

20. FILED....., 19.....

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

If so, specify..... (Signed) *E. C. Shelton*, M. D.
(Address) *Eldon, Mo*

Local Registrar.

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

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