

M. 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.

**D** OCT 20 1939

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

*Chapman*  
**33158**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Pemissot Registration District No. 653-1

(b) Township 1 Primary Registration District No. 4392

(c) City Steele (d) Street No. \_\_\_\_\_ St.

(e) Length of residence in city or town where death occurred 1 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** Anna Elizabeth Burr

(a) Residence, No. Steele, Mo. 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**

**3. SEX** Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Widowed  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** Oct 15th 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>73</u>	<u>11</u>	<u>13</u>	

**OCCUPATION**

**8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.** House Keeper

**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** \_\_\_\_\_

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Missouri 0

**FATHER**

**13. NAME** Tom Young 0

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Mo. 7

**MOTHER**

**15. MAIDEN NAME** Dora Kerner

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Dora Kerner

**17. INFORMANT (ADDRESS)** Chas Durr  
Steele, Mo.

**18. BURIAL, CREMATION, OR REMOVAL**

**PLACE** MtXion Cem. **DATE** Sept 29, 1939

**19. FUNERAL DIRECTOR (NAME) (ADDRESS)** German Undt Co.  
Steele, Mo.

**20. FILED** Oct 5 1939 S. S. Robinson  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** Sept 28, 1939

**22. I HEREBY CERTIFY, That I attended deceased from** Sept 23, 1939, to Sept 28, 1939

I last saw her alive on Sept 28, 1939. Death is said to have occurred on the date stated above, at 5:00 a.m.

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

Malerial fever  
Acute Hepatitis  
Myocardial failure

Date of onset \_\_\_\_\_

Other contributory causes of importance: 23

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 \_\_\_\_\_, 1939

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) J. Chapman, M. D.

(Address) Steele, Mo.

RECEIVED

District Health Officer No. *1039-69*

District File Number *1039-69*

Date Filed *10/9/39*

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33158  
Do not use this space.

1. PLACE OF DEATH

(a) County Pemissot Registration District No. 655-  
(b) Township Steele Primary Registration District No. 4392 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (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 Anna Elizabeth Burr DUI-1-

(a) Residence, No. \_\_\_\_\_ 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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 15- 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>72</u>	<u>11</u>	<u>13</u>		

OCCUPATION  
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

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

FATHER  
13. NAME  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10/29 L. A. ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-28 1917

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him 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:

Date of onset

Other contributory causes of importance:

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) J. R. Chapman, M. D.  
(Address) Steele

SUPPLEMENTARY

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

