

Registration District No. **322**Primary Registration District No. **5446**Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Rural - Franklin**
(If outside city or town limits, write "RURAL" and name of township)(c) Name of hospital or institution: **2**(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)In this community
years, months or days _____3. (a) PRINT FULL NAME **FRANK O. BURGESS 622**3. (b) If veteran, name war **WORLD WAR** 3. (c) Social Security No. **491-03-0671**4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**6. (b) Name of husband or wife **HONES L. BURGESS** 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased **DEC. 21, 1891**
(Month) (Day) (Year)8. AGE: Years **47** Months **10** Days **15** If less than one day _____ hr. _____ min.9. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)10. Usual occupation **FARMER**11. Industry or business **ON FARM**12. Name **ELIJAH BURGESS**13. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)14. Maiden name **MARY SHORT**15. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **John L. Burgess**(b) Address **Springfield R#100**17. (a) **Burial** (b) Date thereof **NOV. 7-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **NATIONAL CEMETERY**18. (a) Signature of funeral director **Willingham & Co.**(b) Address **Springfield Mo.**19. (a) **Nov. 7-1939** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GREENE**(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")(d) Street No. **SPRINGFIELD R#10**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **6**
19**39** year **5** hour **05** minutes **A.** M.21. I hereby certify that I attended the deceased from **July 11-1939**
to **Oct 16-1939**that I last saw him alive on **Oct-16-** 19**39**
and that death occurred on the date and hour stated above.Immediate cause of death **frankly acute indigestion** Duration _____Due to **Cancer Gall Bladder**

Due to _____

Other conditions **Colitis**

(Include pregnancy within 3 months of death)

Major findings: **H6**

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Joe Allison** (M. D. or other) _____Address **156 Public Sq.** Date signed **11/6-39**

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.....

and Warren D. Hobbs #4005
and Eugene Stone Jr.

working under my personal supervision.

Registered Apprentice No. *232*

Signed.....

Warren D. Hobbs

Licensed Embalmer No. *4005*

P. O. Address..... *Springfield Mo*

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

39658

Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 322
(b) Township Franklin Primary Registration District No. 3446
(c) City..... (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.

Registered No.

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from

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

I last saw h..... alive on....., 19..... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
47 10 15

to have occurred on the date stated above, at.....m.

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.....

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

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

Date of onset

13. NAME

Other contributory causes of importance:

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

15. MAIDEN NAME

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

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

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

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

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

PLACE DATE 19

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

19. FUNERAL DIRECTOR (ADDRESS)

Manner of injury.....

Nature of injury.....

20. FILED Nov 7, 1937 Allan Barnes Local Registrar

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

If so, specify

(Signed) Ira Allison, M. D.

(Address) Springfield Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE JR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

