

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH: 1
 (a) County Jasper
 (b) City or town Jasper
 (c) Name of hospital or institution St. John's Hospital
 (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 Oliver W. Burrows
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. 6-11-1

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Miss Maude Burrows 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 27 1877
 (Month) (Day) (Year)

8. AGE: Years 62 Months 6 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Newton, Kentucky (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Joe S. Burrows
 13. Birthplace Tenn. (City, town, or county) (State or foreign country)
 14. Maiden name W. M. M. M. M.
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wife
 (b) Address _____

17. (a) Burial (b) Date thereof Nov 29 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Ballant Cemetery

18. (a) Signature of funeral director W. H. C. C. C.
 (b) Address W. H. C. C. C.
 19. (a) 11-27-39 (b) Ed S. James
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo. (b) County Newton
 (c) City or town Rural - Galeua P. 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. R. R. 2 - Galeua, Kan.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 25 day November
 year 1939 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from May 1, 1939, to Nov 25, 1939, that I last saw him alive on Nov 24, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure

Due to _____
 Due to _____

Other conditions Chronic myocarditis
 (include pregnancy within 3 months of death)

Major findings: ✓
 Of operations _____
 Of autopsy ✓

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or D. O.)
 Address 626 E. 1st St. Bldg Date signed 11-27-39

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.

RECEIVED

District Health Officer No. 8,

District File Number 1239-2511

Date Filed DEC. 7 1939

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.