

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **43460**

Registration District No. **334**

Primary Registration District No. **4197**

Registrar's No. **84**

**1. PLACE OF DEATH:**  
(a) County **Harrison**  
(b) City or town **Bethany**  
(c) Name of hospital or institution: **Bethany 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 **7 years** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Rose Anne Burriss**  
**3. (b) If veteran, name war** \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** **Female** **5. Color or race** **White**  
**6. (a) Single, widowed, married, divorced** **married**  
**6. (b) Name of husband or wife** **Edgar Burriss** **6. (c) Age of husband or wife if alive** **18 1/2 years**  
**7. Birth date of deceased** **12 28 1883**  
(Month) (Day) (Year)

**8. AGE:** Years **56** Months **0** Days **19** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** **Wale, Indiana** (City, town, or county) (State or foreign country)

**10. Usual occupation** **House work**

**11. Industry or business** \_\_\_\_\_

**MOTHER, FATHER**  
**12. Name** **Joseph Burriss**  
**13. Birthplace** **Do not know**  
**14. Maiden name** **Amanda Carter**  
**15. Birthplace** **Do not know**

**16. (a) Informant's own signature** **Edgar Burriss**  
**(b) Address** **Bethany Missouri**  
**17. (a) (Burial, cremation, or removal)** **removed** **(b) Date thereof** **12-22-39**  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** **Arlington Park**

**18. (a) Signature of funeral director** **S. M. Haas**  
**(b) Address** **Bethany Mo.**  
**19. (a) 12-21-39 (b) G. L. Williams**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Harrison**  
(c) City or town **Bethany** (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Dec.** day **21** year **1939** hour **5** minute **20** A.M.  
**21. I hereby certify that I attended the deceased from** **12-4**, 19**39**, to **12 21**, 19**39**; that I last saw **her** alive on **12-20**, 19**39**; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Nephritis**  
Due to **Renal, Cardiac disease & Hypertension**  
Due to \_\_\_\_\_

Other conditions **Carbuncle on neck**  
(Include pregnancy within 3 months of death)

Major findings: **Carbuncle neck**  
Of operations \_\_\_\_\_  
Of autopsy **neck - 12/1**

**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) (b) Means of injury \_\_\_\_\_  
**23. Signature** **G. L. Williams** (M. D. or other) **12/21/39**  
**Address** **Bethany Mo.** Date signed \_\_\_\_\_

Duration **5 1/2 yrs**  
**10 years**  
**30 days**  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically

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. 11;

District File Number 140-1942

Date Filed JAN 13 1940

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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.**