

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

7920  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Ray Registration District No. 744  
 (b) Township Richmond Primary Registration District No. 6976B  
 (c) City Richmond (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** John B. Burns

(a) Residence, No. Richmond Rural 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 <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Luella Burns</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>June 25, 1870</b>		
7. AGE	YEARS	MONTHS
	69	8
		10
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Farming</b>		
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) <b>Richmond Mo.</b>		
FATHER	13. NAME <b>William Burns</b>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown Va.</b>	
MOTHER	15. MAIDEN NAME <b>Kansas Lile</b>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Richmond Mo.</b>	
17. INFORMANT <b>Gene Burns</b> (ADDRESS) <b>Richmond Mo.</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Hickory Grove</b> DATE <b>Mar. 6, 1940</b>		
19. FUNERAL DIRECTOR (NAME) <b>E. Thurman</b> (ADDRESS) <b>Richmond Mo.</b>		
20. FILED <b>Mar-6</b> 1940 <b>Mabel Jackson</b> Local Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 4, 1940**

22. I HEREBY CERTIFY That I attended deceased from **man** 1939 to **Mar 4** 1940  
 I last saw him alive on **Feb 29** 1940 Death is said to have occurred on the date stated above, at **4:45 P.M.**  
 The principal cause of death and related causes of importance were as follows:  
**Chronic Interstitial Nephritis.**

Other contributory causes of importance: **1935**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis **clinical** Was there an autopsy? **No**

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? **No**  
 If so, specify \_\_\_\_\_ (Signed) **G. W. Gaines** M. D.  
 (Address) **Richmond, Mo.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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MAI 2 4 1934

RECEIVED  
District Health Officer No. 8,  
District No. 31874  
Date Filed

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, \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed E. Thurman

Licensed Embalmer No. 2073

P. O. Address Richmond 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7920**  
Registrar's No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **744**

Primary Registration District No. **5976B**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County **Ray**  
(b) City or town **Richmond, Rural**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John B. Burns**  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**69 8 10** hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **Mar 6 - 1940** (b) **Malcolm Jackson** (Date received local registrar) (Registrar's signature)

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

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH Month **Mar** day **4**  
year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Due to.....  
Due to.....  
Other conditions (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 **G. W. Gains** (M. D. or other)  
Address **Richmond, Mo** Date signed.....

SUPPLEMENTARY

