

Registration District No. 216 Primary Registration District No. 524 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clinton
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (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)
 In this community Life years, months or days

3. (a) PRINT FULL NAME Willard Samuel Burr

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white

6. (b) Name of husband or wife Kathrine Burr 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased December 5 1884
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>5</u>	<u>28</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert Burr
 13. Birthplace Virginia
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Hughs
 15. Birthplace Clinton County Missouri
 (City, town, or county) (State or foreign country)

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

17. (a) Burial (b) Date thereof June 4 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osborn Missouri

18. (a) Signature of funeral director O'Brien-Lyon
 (b) Address Plattsburg Missouri

19. (a) June 3 1940 (b) Mr. John Ray
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Southeast of Osborn
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
 year 1940 hour Five minute ten A. M.

21. I hereby certify that I attended the deceased from Dec., 1938, to June, 1940
 that I last saw him alive on June 1, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of Lung Duration 1 Mo.
 Due to Carcinoma Brain 2 Mo.
 Due to Carcinoma face 18 Mo.
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings:
 Of operations _____
 Of autopsy None
 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? _____

(Specify type of place) _____
 While at work? _____ (e) Means of injury _____

28. Signature W. B. Shalving (M. D. or other) MD
 Address Plattsburg Mo Date signed June 3 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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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RECEIVED

District Health Officer No. 111

District File Number 740-1138

Date Filed JUL 8 1940

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 Danell D. Lyon

Licensed Embalmer No. 3640

P. O. Address. Plattsburg Missouri

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. 215-47

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 210

Primary Registration District No. 2290

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Clinton
(b) City or town Plattsburg
(If outside city or town limits, write "RURAL" and name of township)
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Wm Samuel Burr

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 _____

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

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

8. AGE: Years 55 Months 5 Days 28 If less than one day _____ h _____ 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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 June day 2 year 1948 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 Carcinoma of

Brain

Due to Carcinoma of Brain

Due to Carcinoma of face

just anterior to lower lobe

of left ear.

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 W. B. Spalding M. D. or other) _____
Address Plattsburg Mo

SUPPLEMENTAL

