No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34394

FILED NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3910

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Colney Clinic 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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County —
(c) City or town Burlingame Kansas
(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.

3. (a) PRINT FULL NAME Baby Burns
3. (b) If veteran, name war — Baby Burns
3. (c) Social Security No. —

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Oct (Month) 9 (Day) 1940 (Year)

8. AGE: Years — Months — Days — If less than one day — hr. 30 min.

9. Birthplace Kansas City (City, town, or county) MO (State or foreign country) 0
10. Usual occupation None
11. Industry or business —
FATHER
12. Name Maurice Burns
13. Birthplace Burlingame KS. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Maudie Gurss
15. Birthplace Burlingame KS (City, town, or county) (State or foreign country)
16. (a) Informant Maurice Burns
(b) Address Burlingame KS
17. (a) Burield (Burial, cremation, or removal) (b) Date thereof Oct 11-40 (Month) (Day) (Year)
(c) Place: burial or cremation Burlingame KS
18. (a) Signature of funeral director Passantino Bros
(b) Address KS, MO
19. (a) 10-10-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9 year 1940 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from — , 19 — , to — , 19 — ; that I last saw h — alive on — , 19 — ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Asphixia due to cord impingement	
Due to Malposition of Fetus	
Due to 160B	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? — (Specify type of place)
While at work? — (e) Means of injury 3

23. Signature Dorland D. Shaw (M. D. or other) DO
Address 2105 Independence Date signed Oct 10 1940

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.