

DEPARTMENT OF COMMUNITY HEALTH
FILED NOV 25 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36257
State File No. _____
Registrar's No. 994

Registration District No. 774

Primary Registration District No. 4465

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
In this community _____ years, months or days

8. (a) PRINT FULL NAME Essie Mae Burns

8. (b) If veteran, name war no 3. (c) Social Security No. ✓

4. Sex F. 5. Color or race W 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased Oct 7 1940
(Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Woe Run Mo.
(City, town, or copesy) (State or foreign country)

10. Usual occupation at home

11. Industry or business ✓

12. Name Francis Burns

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

14. Maiden name Mary Williams

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

16. (a) Informant Alva Tongway

(b) Address Flat River, Mo.

17. (a) Burial (b) Date thereof Oct 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 2003. Woe Run Mo.

18. (a) Signature of funeral director Albush Bros

(b) Address Flat River, Mo.

19. (a) 10/7/40 (b) O. B. Starnes MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois
(c) City or town Flat River
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7th
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 1940 to Oct 7 1940
that I last saw him alive on Oct 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach metastasizing to intestines
Due to intestines

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy ✓

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?

W.A.I. (Specify type of place) (e) Means of injury _____
While at work? _____

23. Signature O. B. Starnes (M. D. or other) _____
Address Flat River Mo Date signed 10/7/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 36257

Registration District No. 774

Primary Registration District No. 4465

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flatt River
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Essie May Burns

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased: Oct - 7 - 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/7/40 (b) [Signature]
(Date of 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

DECEASED CERTIFICATION

20. DATE OF DEATH: Month Oct day 7
year 1940 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 _____

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 other) _____

Address Flatt River _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

