

DEC 12 1940
Registration District No. **2**

Primary Registration District No. **202**

Registrar's No. **62**

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 give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County **Andrew**
(b) City or town **Bolckow**
(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) **2**
(d) Length of stay: In hospital or institution **2**
In this community **8 mo 21 Days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARVIN RAY BURRINGTON**
3. (b) If veteran, name war **-** 3. (c) Social Security No. **none**
4. Sex **m** 5. Color or race **w**
6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **" "** years
7. Birth date of deceased **March 13 1940**
(Month) (Day) (Year)

8. AGE: Years **-** Months **8** Days **21** If less than one day hr. **-** min. **-**

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

10. Usual occupation **-**

11. Industry or business **-**
MOTHER FATHER {
12. Name **John L. Burrington**
18. Birthplace **Hentry Co Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Elia Irene Showers**
15. Birthplace **Hentry Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. L. Burrington**
(b) Address **Bolckow Mo**

17. (a) **B** (b) Date thereof **12-8-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Ann's**

18. (a) Signature of funeral director **E. C. Breit**
(b) Address **Savannah Mo**

19. (a) **Dec 9, 1940** (b) **W. S. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Andrew**
(c) City or town **Bolckow**
(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 **4** year **1940** hour **5** minute **A. M.**
21. I hereby certify that I attended the deceased from **Dec 27** 19**40** to **Dec 4** 19**40**
that I last saw him alive on **Dec 3rd** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Branch Pulmonary** Duration **1**
Due to **-**
Due to **-**

Other conditions (Include pregnancy within 3 months of death) **-**

Major findings: Of operations **none**
Of autopsy **none**

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 **A. H. Kelly** (M. D. or other) **-**
Address **Bolckow Mo** Date signed **Dec 9**

107W

[Faint, illegible text]

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..... *E. C. Breit*

Licensed Embalmer No. *2658*

P. O. Address *Savannah*

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. 38001
Registrar's No. 62

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 2

Primary Registration District No. 202

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

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Bolekov
(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)

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.

3. (a) PRINT FULL NAME Marvin Ray Buffington
(b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH Month Dec day 4
year 1940 hour _____ minute _____ M.

4. Sex M 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 _____ year
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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.

8. AGE: Years Months Days If less than one day
8 21 _____ hr _____ min.

Immediate cause of death Broncho Pneumonia
Due to and following pneumonia 3 weeks
Duration

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

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

10. Usual occupation _____

Major findings: _____
Of operations _____

11. Industry or business _____

Of autopsy _____

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) Feb, 1941 (b) W B Wood (Registrar's signature)

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 A. H. Kelley (M. D. or other)
Address Bolekov _____ Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL MEDICAL CERTIFICATION

