S. No. 2
M—1-4-41
v. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 25 1942

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 9510

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1414

**1. PLACE OF DEATH:**

(a) County Jackson
(b) City or town KC Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1400 W. 24th Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Home (Specify whether
In this community 23 yrs
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1400 W. 24th Str
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARRIE BURRIS

3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FE 3
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CHARLES BURRIS
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Nov (Month) 30 (Day) 1884 (Year)

8. AGE: Years 57 Months 4 Days 8 If less than one day ___ hr. ___ min.

9. Birthplace Jefferson Texas (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home
FATHER
12. Name Dont Know
13. Birthplace Dont Know (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know (City, town, or county) (State or foreign country)
16. (a) Informant Charles Burris
(b) Address 1400 W. 24th Str.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-42 (Month) (Day) (Year)
(c) Place: burial or cremation West Lawn-KC Ks.
18. (a) Signature of funeral director Flynn + Greenstreet
(b) Address 1819 E. 15th ST.
19. (a) 4-9-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month ___ day 4-8-42
year ___ hour ___ minute ___ M.

21. I hereby certify that I attended the deceased from 2 45 a, 19__ to ___, 19__;
that I last saw h__ alive on ___, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease

Due to 93d

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

23. Signature [signature] (M. D. or other) 3
Address KC Mo. Date signed

(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 Edw. G. Evans

Licensed Embalmer No. 3876

P. O. Address 1814 615 N 6 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, fact should be so stated above.**