

FILED JUL 23 1942
Registration District No. **1608**

Primary Registration District No. **6001**

1. PLACE OF DEATH:

(a) County **St Charles**
(b) City or town **Rural** *WARRINGTON, MO.*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
Specify whether
In this community **1 year 6 months**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Charles** **92**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Near Cottiville, Mo.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **X**
If yes, name country _____

3. (a) PRINT FULL NAME **Frank Burns**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **490-1A-4358**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Emma Peters** 6. (c) Age of husband or wife if alive **39** years
7. Birth date of deceased **Dec 10 1890**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 6 1 hr. min.

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

10. Usual occupation **Labor**

11. Industry or business _____

MOTHER FATHER { 12. Name **Robert Scott Burns**
13. Birthplace **Ill**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Conard**
15. Birthplace **Dont Know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emma Peters**
(b) Address **St Peters Mo**

17. (a) **Burial** (b) Date thereof **June 14, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cottiville, Mo.**

18. (a) Signature of funeral director **Thomas M. Muehling**
(b) Address **Wentzville Mo**

19. (a) **June 12-42** (b) **E. A. Feisley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **11**
year **1942** hour **6** minute **PM** M.

21. I hereby certify that I attended the deceased from **May 30, 1942**
to **June 5, 1942**
that I last saw him alive on **June 5, 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure** Duration _____

Due to _____

Due to _____

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 _____

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 **H. Goodman** M. D. or other _____

Address **St. Charles Mo** Date signed **6/12/42**

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

12
00

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 *Morris M. Minkberg*

Licensed Embalmer No. 2461

P. O. Address Wentzville, 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.

Registration District No. **16013**

Primary Registration District No. **6001**

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles

(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 years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Burns

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 m

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

7. Birth date of deceased Dec 10 1891
(Month) (Day) (Year)

8. AGE: Years 51 Months 6 Days 18
(If less than one day in min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER { 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____ Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I have seen him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Cardiac failure
CHRONIC ENDOCARDITIS

Due to Renal Insufficiency

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-22127