

FILED SEP 9 1942

Registration District No. 164

Primary Registration District No. 3-2-3-5152

Registrar's No. 89

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
323 McGoodin Mc Goodwin 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")
(d) Street No. 323 McGoodin Mc Goodwin
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Louise Margaret Bruns

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Fred Ernest Bruns 6. (c) Age of husband or wife if alive 55
7. Birth date of deceased Feb. 13 1893
(Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Mt. Huldu Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Hermann Wallis
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Martha Borches
15. Birthplace Cole Camp Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Red E. Bruns
(b) Address 323 Mc Goodin

17. (a) Burial (b) Date thereof Aug. 11, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director W. S. Wilcox

(b) Address

19. (a) (b) (c) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8 year 1942 hour 12 Noon minute M.

21. I hereby certify that I attended the deceased from Aug 8 1942 to Aug 8 1942 that I last saw her alive on Aug 8 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other conditions 83a
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

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 D

23. Signature Wm Patterson (M. D. or other)
Address Warrensburg Mo Date signed 8-12-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1901

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9-4-42

AUG 29 1942

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. 3557

P. O. Address

Leeton, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7502**
Registrar's No. **89**

Registration District No. **164** Primary Registration District No. **3032**

1. PLACE OF DEATH:
(a) County **Johnson**
(b) City or town **Warrensburg**
(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 years, months or days)

3. (a) PRINT FULL NAME **Louise Margaret Burns**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife **Fred** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 13 1895**
(Month) (Day) (Year)

8. AGE: Years **49** Months **5** Days **13** If less than one day _____ min.

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

10. Usual occupation _____
11. Industry of business _____

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)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address **Warrensburg, Missouri**

19. (a) **Aug. 11, 1942** (b) **Leola M. Williams**
(Date received by 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** Day **11** Year **1942** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

MOBILE PAPER

