No. 2
-1-4-41
5-17-39
I X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7887

FD MAR 12 1943

Registration District No. 3148

Primary Registration District No. 4511

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Harris
(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 Life

2. USUAL RESIDENCE OF DECEASED: 105

(a) State Mo (b) County Sullivan 0

(c) City or town Harris 0
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JOHN COLEMAN BURTON

3. (b) If veteran, name war —

3. (c) Social Security No. 448-14-8539

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Aug (Month) 28 (Day) 1875 (Year)

8. AGE: Years 67 Months 5 Days 23 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

FATHER
12. Name Mack Burton
13. Birthplace — (City, town, or county) — 9 (State or foreign country)

MOTHER
14. Maiden name Edwina Nash
15. Birthplace — (City, town, or county) — 9 (State or foreign country)

16. (a) Informant Mrs Nellie Burton
(b) Address Harris Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director Judd & Payne
(b) Address Newtown Mo

19. (a) Feb 5 1943 (Date received local registrar) (b) Mrs Lelie Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 year 1943 hour 9:30 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from Jan 31-43 ____, 19__ to Jan 31 19 43 that I last saw him alive on Jan 30 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) —	
Major findings: Of operations — 94a	
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 —
(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 U. S. Bradley (M. D. or other)
Address ____ Date signed ____

1183 (Licensed Embalmer's Statement on Reverse Side)

OCT 9 1944

RECEIVED
District Health Officer No. 10
District File Number 3-43508
Date Filed MAR 1-1-1943

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt.

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.