

FILED FEB 7 1944

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**5612 East 29th Terrace**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community **30 years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5612 East 29th Terrace**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **THOMAS J BURNS**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Catherine Burns** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: **April 3 1868**  
(Month) (Day) (Year)

8. AGE: Years **75** Months **9** Days **12** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: **Brookfield Mo. D**  
(City, town, or county) (State or foreign country)

10. Usual occupation **retired eng**

11. Industry or business **Supt. W.P.A**

12. Name **John Burns**

13. Birthplace **Ireland**  
(City, town or county) (State or foreign country)

14. Maiden name **UNK**  
(City, town or county) (State or foreign country)

15. Birthplace **UNK**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Rose M Middlecott**  
(b) Address **5612 E 29 Terrace**

17. (a) **Burial** (b) Date thereof **1-18-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Calvary R.C. Ch.**

18. (a) Signature of funeral director **Dwight P. Cabin**  
(b) Address **20 1/2 East 29th Terrace**

19. (a) **Jan 17-1944** (b) **W. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **15th** day **Jan**  
year **1944** hour **3:05** minute **P** M.

21. I hereby certify that I attended the deceased from **January 20th 6:30 to Jan 15 1944**  
that I last saw him alive on **January 14 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypostatic Pneumonia**  
**(A. O. B.)**

Due to: **Atherosclerosis**  
**Coronary Artery D.**

Due to: **Senility**

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

Major findings: Of operations **✓**  
Of autopsy **2**

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 **Calvin Allen** (Dr. D. or other)  
Address **100 Professional Bldg** Date signed **1/17/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 2 9 1944

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**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.....

P. O. Address.....

**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.**