

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas city
(c) Name of hospital or institution: Kansas city T.B. Hosp. (1)
(d) Length of stay: In hospital or institution 2 yrs 7 mos 5 ds
In this community 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas city
(d) Street No. 2012 Prospect
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME DEWITT BURNS

3. (b) If veteran, name war NO
3. (c) Social Security No. 3011853

4. Sex male
5. Color or race colored
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Abbie Burns
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased December 14 1899

8. AGE: 54 Years 55 Months 78 Days 20 hr. min.

9. Birthplace Child 18 Mississippi

10. Usual occupation Laborer

11. Industry or business

12. Name Silas Burns

13. Birthplace unknown

14. Maiden name Laura Hank

15. Birthplace unknown

16. (a) Informant Records of T.C. T.B. Hosp.
(b) Address N.C. Mo.

17. (a) Removal (b) Date thereof 9-8-44
(c) Place: burial or cremation Oakland Miss.

18. (a) Signature of funeral director Nathan W. Thaller
(b) Address 1520 N. 5th St.

19. (a) 9-8-44 (b) T. E. Brown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 2nd year 1944 hour 1:00 minute P.M.

21. I hereby certify that I attended the deceased from 1-26 1942 to 9-2 1944 that I last saw him alive on September 2 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 13 lb

Major findings: Of operations
Of autopsy Same as above

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Means of injury

23. Signature: Matthew J. Noon (M. D. or other)
Address: 212 S. 1st St. Date signed 9/6/44

Duration 5 years
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Nathan Whatcher*

Licensed Embalmer No. *2720*

P. O. Address *1520 N. 5th St*

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.