

FILED OCT 9 1944
Registration District No. **2**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1714 Bellevu, Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 years** (Specify whether
In this community **50 years**
years, months or days)

3. (a) PRINT FULL NAME **Jennie Augusta Burri**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Chris Burri** 6. (c) Age of husband or wife if alive **7** years

7. Birth date of deceased **August 7 1873**
(Month) (Day) (Year)

8. AGE: Years **71** Months **1** Days **23** If less than one day
hr. min.

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

10. Usual occupation **Home**

11. Industry or business

12. Name **John Lodholz**

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

14. Maiden name **Rosina Buck**

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

16. (a) Informant **Milton Burri**

(b) Address **1714 Belevu St., St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **10/4/1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland, Cemetery**

18. (a) Signature of funeral director **Walter Meierhoffer**

(b) Address **1302 Faraon, St. St. Joseph, Mo.**

19. (a) **10/3/44** (b) **Walter Meierhoffer**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** /
(c) City or town **St. Joseph** /
(If outside city or town limits, write "RURAL")
(d) Street No. **1714 Bellevu, Street** 7
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **30th**
year **1944** hour **1** minute **30⁰** M.

21. I hereby certify that I **viewed** the deceased from **Sept 30th 1944** to **Sept 30th 1944**,
that I last saw h. **alive on** **Sept 30th 1944**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coronary Thrombosis** Duration **1 day**

Due **Chronic Angina Pectoris** **94** 1 year

Due to **Woman apparently died suddenly while alone**

Other condition **in her home, without previous serious illness or disability.**

Major findings: **Of operation: previous serious illness or disability.** Of autopsy **no! she has suffered several attacks of acute indigestion**

22. If death was due to external cause, 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) (c) Means of injury?

23. Signature **H F Mundy, Coroner**
Address **104 So 3d St** Date signed **9/30/44**

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

MOTHER FATHER

MAR 19 1949

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

Robert C. Harrington

Licensed Embalmer No.

3258

P. O. Address

St. Joseph, 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.