No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38082

Registration District No. 1

Primary Registration District No. 5596

Registrar's No. 71

1. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: Rural. VALLE (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.7, D #2, De Soto, Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: ✓ (Specify whether)

In this community: 20 Years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jefferson

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No.: R.7, D #2, De Soto, Mo (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Florence E. Burlison

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ?

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Rose Wiggins

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: Jan. (Month) 30 (Day) 1872 (Year)

8. AGE: Years 72 Months 9 Days 19 If less than one day: hr. min.

9. Birthplace: Johnson Co. (City, town, or county) — Illinois (State or foreign country)

10. Usual occupation: Farming.

11. Industry or business: ✓

MOTHER FATHER

12. Name: John R. Burlison

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

14. Maiden name: Unknown

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

16. (a) Informant: John R. Burlison

(b) Address: De Soto Mo. R.2.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-22-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Mammoth Cemetery

18. (a) Signature of funeral director: J. Lee Mothershead

(b) Address: De Soto, Mo.

19. (a) 11-22-44 (Date received local registrar) (b) Kerw Spencer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov day: 19th year: 1944 hour: minute: M.

21. I hereby certify that I attended the deceased from Nov 18th, 1944, to Nov 19, 1944 that I last saw him alive on Nov 18, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory Influenza	2da
Due to: Brights Disease	3yrs
Due to: Senility	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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: 0

23. Signature: F. A. Elders (M. D. or other) MD

Address: De Soto Mo. Date signed 11/20/44

347

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-6-44

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 Lee McCluskeac

Licensed Embalmer No. 3531

P.O. Address Desoto Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
I—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22

Registration District No. 963 Primary Registration District No. 5596 Registrar's No. 71

1. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: Rural Valley

(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

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

3. (a) PRINT FULL NAME: Florence E. Burleson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 30 (Day) (Year)

8. AGE: Years 72 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw him alive on , 19 ;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory influenza	
Due to: Bronchial Pneumonia Chronic	
Due to: Senility	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 (M. D. or other)

Address Date signed 12/16/46

SUPPLEMENTARY

131b

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

38082