

FILED FEB 13 1945

Registration District No. 212

Primary Registration District No. 5901

Registrar's No. 1

**1. PLACE OF DEATH:**  
(a) County Carroll  
(b) City or town Burritt  
(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  
In this community 1 years, months or days)

**3. (a) PRINT FULL NAME** JOHN P BURRUSS  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** male **5. Color or race** white **6. (a) Single, widowed, married, divorced, single**  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_  
**7. Birth date of deceased** March 17 1872  
(Month) (Day) (Year)

**8. AGE:** Years 72 Months 10 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Carroll Mo.  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Farming

**11. Industry or business** \_\_\_\_\_

**12. Name** J F Burruss  
**13. Birthplace** Carrollton Ill  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Flora Parton  
**15. Birthplace** Miami Mo  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Genell Burruss  
**(b) Address** Grand Pass Mo

**17. (a) Burial, cremation, or removal** Carroll **(b) Date thereof** Jan 13 1945  
(Month) (Day) (Year)

**(c) Place: burial or cremation** Miami cemetery

**18. (a) Signature of funeral director** Geo J Jiloh  
**(b) Address** Miami Mo

**19. (a) 1-16-1945** **(b) Foster Fisher**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo (b) County Carroll  
(c) City or town on farm  
(If outside city or town limits, write "RURAL")  
(d) Street No. Burritt Mo  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Jan day 10<sup>th</sup>  
year 1945 hour 5:00 PM M.

**21. I hereby certify that I attended the deceased from** Carroll 1919 to 19;  
that I last saw him alive on \_\_\_\_\_ 1919;  
and that death occurred on the date and hour stated above.

Immediate cause of death Stem fracture & Brain Compression

Due to Blow to head due to falling  
Due to tree

Other conditions 175 lb  
(Include pregnancy within 3 months of death)

Major findings: Excess Blood  
Of operations Fracture  
Of autopsy \_\_\_\_\_

**22. If death was due to external causes, fill in the following:**  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 1-10-45  
(c) Where did injury occur on farm  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
On farm  
While at work? no (Specify type of place) (e) Means of injury Falling tree  
**23. Signature** Charles Rutt  
Address Carroll Mo Date signed 1-11-45

Duration 6 hrs  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

RECEIVED

Health Officer No. 8,

Date Filed 2-9-75

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 W. Campbell Jr.  
Licensed Embalmer No. 3469  
P. O. Address Marshall N.

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 56

Primary Registration District No. 5201

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town De Witt Rural  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John P. Burruss

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 s

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

7. Birth date of deceased march 17  
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 6 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY



S-1921