S. No. 2
M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9052

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 379

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

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: Mo. Meth Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County DEKALB
(c) City or town AMITY (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 No.

3. (a) PRINT FULL NAME ALBERT HOY BURRESS
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex MALE
5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEB-9 1875 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
70	1	29	hr. min.

9. Birthplace RAY COUNTY MO (City, town, or county) (State or foreign country)
10. Usual occupation RETIRED MINISTER
11. Industry or business
FATHER 12. Name THOMPSON N. BURRESS
13. Birthplace NEW YORK (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name MARY EVILSIZER
15. Birthplace PA. (City, town, or county) (State or foreign country)
16. (a) Informant R. N. Burress
(b) Address 2246 N.E. Lyndale St. Minneapolis, Minn
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation AMITY MO
18. (a) Signature of funeral director FILLHER FUNERAL HOME
(b) Address MAYSVILLE MO
19. (a) 4-10-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 8 year 1945 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Apr 7, 1945, to Apr 8, 1945,
that I last saw him alive on Apr 8, 1945,
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	unknown
Arteriosclerosis General	"
Due to	
Due to	
Other conditions (mal nutrition from starvation) (Include pregnancy within 3 months of death)	unknown

Major findings:
Of operations none 93d
Of autopsy none

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 E. M. Shores (M. D. or other) M.D.
Address 317 Kirkpatrick Bldg St. Joseph Mo Date signed 4-9-45

1347

(Licensed Embalmer's Statement on Reverse Side)

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. 3960

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.