S. No. 2
OM—5-43
v.-5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29569

Registration District No. 149 Primary Registration District No. 7002 Registrar's No. 3656

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Little Sisters of the Poor 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 Months (Specify whether
In this community 16 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5331 Highland 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME THOMAS BURNS
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lucille Burns
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased January 20 1856 (Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 9 If less than one day hr. min.

9. Birthplace New York 1 (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Thomas Burns
FATHER 13. Birthplace No record 7 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Margaret Rochford
MOTHER 15. Birthplace No record 9 (City, town, or county) (State or foreign country)
16. (a) Informant Sister St. Theile
(b) Address 5331 Highland Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery
18. (a) Signature of funeral director Quirk & Robinson Co
(b) Address 20 West Linwood
19. (a) 9-4-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 29th day August year 1945 hour 10:00 minute A M.
21. I hereby certify that I attended the deceased from May 10, 1945, to Aug 29, 1945, that I last saw him alive on Aug 29, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	5 years
Due to Cardiac Decompensation	7
Due to Generalized Arteriosclerosis	12 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 956 2
Of autopsy No

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 0
23. Signature John T. Skinner (M. D. or other) MD
Address 1 Bryant Bldg Date signed 8/31/45

(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, ~~only~~.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....Dixon L. Kepley

Licensed Embalmer No.....4225

P. O. Address.....Sedalia 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.