U. S. No. 2
10M—8-43
Rev. 5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33143

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1081

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: Isolation Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Days ed (Specify whether years, months or days)

In this community 14 Daysed

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeKalb 7 2

(c) City or town Clarksdale 0
(If outside city or town limits, write "RURAL")

(d) Street No. None 0
(If rural, give location)

(e) Citizen of foreign country? No 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Danny Burris

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 6 (Day) 1945 (Year)

8. AGE: Years	Months	Days	If less than one day
0	6	0	hr. min.

9. Birthplace Clarksdale (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation At Home.

11. Industry or business

FATHER
12. Name Frank Burris
13. Birthplace Clarksdale (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Ida Sample
15. Birthplace Mo. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Frank Burris
(b) Address Clarksdale, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/6/45 (Month) (Day) (Year)

(c) Place: burial or cremation Clarksadale, Mo.

18. (a) Signature of funeral director Fleeman & Son Inc.
(b) Address St Joseph, Mo.

19. (a) Oct. 10, 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1945 hour 10 minute 30 p M.

21. I hereby certify that I attended the deceased from Sept 27 1945 to Oct 6 1945 that I last saw him alive on Oct 6 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Meningitis meningococcal	14 da
and Friedlanders Bacillis	"
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 0	
Major findings: Of operations Spinal puncture proved above diagnosis	
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 H Rogi Moore M.D. (M.D. or other)

Address St Joseph Mo Date signed 10/8/45

1428 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER not

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 L Yaple

Licensed Embalmer No. 3308

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.