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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 18/1

Primary Registration District No. 5393

Registrar's No. 17

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

1. PLACE OF DEATH:
(a) County Douglas
(b) City or town Missouri Rural Benton
(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 Missouri (b) County Douglas R 1
(c) City or town Ava Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Burris
3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Warren Burris
6. (c) Age of husband or wife if alive years

7. Birth date of deceased January (Month) 12, (Day) 1883 (Year)

8. AGE: Years 62 Months 8 Days 25 If less than one day hr. min.

9. Birthplace Mt. Grove, Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name H. L. Martin
13. Birthplace Unknown (City, town, or county) ? (State or foreign country)
14. Maiden name Allie Jane Coffman
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Warren Burris
(b) Address Ava, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Ava

18. (a) Signature of funeral director Clinkingbeard Funeral Home
(b) Address Ava, Missouri

19. (a) Oct. 29-45 (Date received local registrar) (b) Vestal Brashears (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7
year 1945 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from , 19 , to Oct 7 , 1945 that I last saw h alive on Oct 7 - 1945 , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Embolism	30 hr
Due to: metastasis from Ca of Breast	2 yr
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 50	

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 M C Gentry (M. D. or other)
Address Ava Mo Date signed 10-11-45

1441

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number 1145-1104
Date Filed NOV 14 1945

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 B Hutchison

Licensed Embalmer No. 3431

P. O. Address Ava 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.