

FILED JAN 21 1946

Registration District No. 107

Primary Registration District No. 5608

Registrar's No. 213

1. PLACE OF DEATH:

(a) County Warren Co.
(b) City or town Marion Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Deerpawater
(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 Margaret White Burrus

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or face W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife R. N. Burrus 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 29 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mathews C White

13. Birthplace Unknown Ky
(City, town, or county) (State or foreign country)

14. Maiden name Marta Jane White

15. Birthplace Unknown Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Cliff Burrus

(b) Address Appleton City Mo

17. (a) Rural (b) Date thereof 12-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City Mo

18. (a) Signature of funeral director Oscar P. Hoff

(b) Address Appleton City Mo

19. (a) 12-29-1945 (b) R. R. Harvey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sh. Clair
(c) City or town Appleton City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Deerpawater
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27
year 1945 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 1 1945 to Dec 27 1945
that I last saw her alive on Dec 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Uremic Coma
Hypertension
Due to Chronic Nephritis

Duration

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) (c) Means of injury _____

23. Signature R. R. Harvey M. D. or other M.D.
Address Appleton City Date signed 12-29-45

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

100130

12-45-1347
1-15-46

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..... *Oscar F. Eckhoff*

Licensed Embalmer No. *3942*

P. O. 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.