

FILED APR 10 1946 STANDARD CERTIFICATE OF DEATH

State File No. **10040**

Registration District No. **195**

Primary Registration District No. **5715**

Registrar's No. **9**

1. PLACE OF DEATH:

(a) County **McDONALD**
 (b) City or town **JANE RURAL**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **McDONALD**
 (c) City or town **JANE Mo.**
(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 _____

3. (a) PRINT FULL NAME

Nellie Anvilla Burbank
 (b) If veteran, name war **L**
 (c) Social Security No. **L**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20**,
 year **1946** hour **7** minute **30 AM**.
 21. I hereby certify that I attended the deceased from **Feb. 20**,
 19**45** to **March 20**, 19**46**
 that I last saw her alive on **March 17**, 19**46**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Failure of Compensation**
Duration

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **W.F. Burbank** 6. (c) Age of husband or wife if alive **71** years
 7. Birth date of deceased: **Feb. 20 1876**
(Month) (Day) (Year)

8. AGE: Years **70** Months **1** Days **0** If less than one day _____ hr. _____ min.

Due to **Apoplexy, several in the last Year.**
 Due to **Arteriosclerosis** **5 yrs.**

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

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

Major findings:
 Of operations _____
 Of autopsy **83**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

11. Industry or business **L**

12. Name **Titus Thomas**

13. Birthplace **Mo. U**
(City, town, or county) (State or foreign country)

14. Maiden name **CAREY TAYLOR**

15. Birthplace **Mo. U**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. BURBANK**

(b) Address **JANE, Mo.**

17. (a) **BURIAL** (b) Date thereof **3-22-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Simsbury Cemetery**

18. (a) Signature of funeral director **Chas. W. Williams**

(b) Address **Goodman, Mo.**

19. (a) **4-4-46** (b) **Mo. B. E. Bradley**
(Date received local registrar) (Registrar's signature)

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)

23. Signature **J. Worling Peremar** (M.D. or other) **R.O.**
 Address **Pleville, Mo.** Date signed **Mar 22 1946**

MOTHER FATHER

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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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 9

Registration District No. 195

Primary Registration District No. 5715

1. PLACE OF DEATH:

(a) County Mc Donald
(b) City or town Jane Rural
(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
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Nelle A. Burbank

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

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

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

7. Birth date of deceased Feb 20
(Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____ (less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (Date received local registrar) (b) Mrs. B. E. Bradley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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 _____

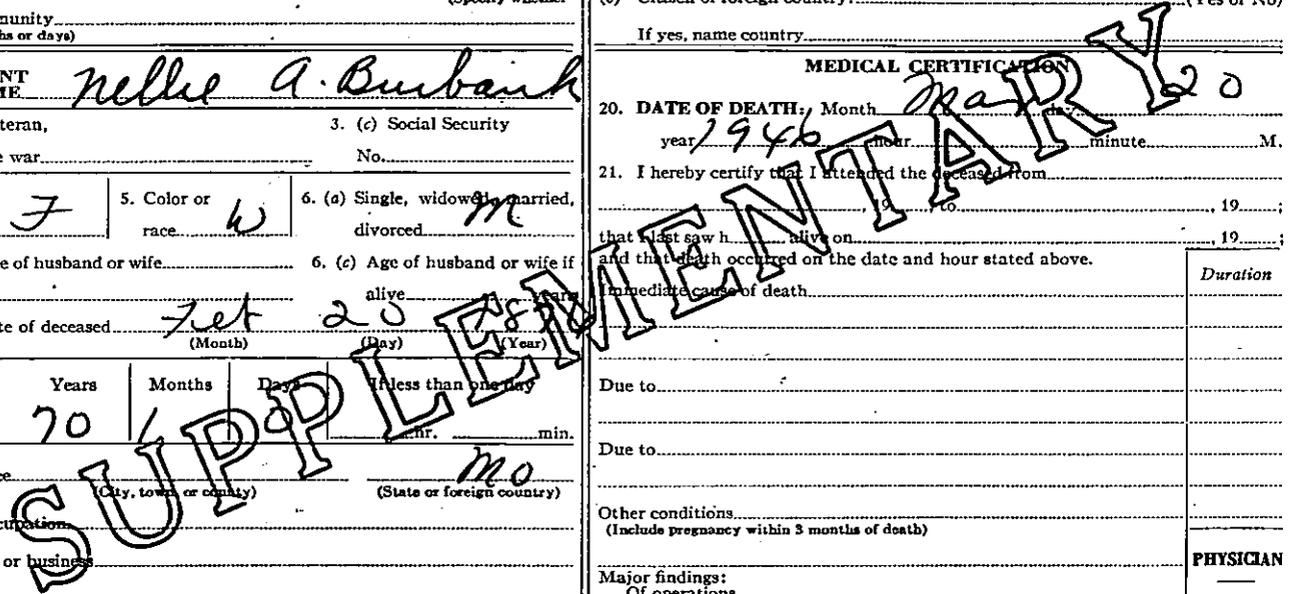
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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