

FILED APR 29 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1803

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:  
1808 1/2 Forest /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 25 years  
years, months or days)

3. (a) PRINT FULL NAME

William Burris

3. (b) If veteran, name war World War I  
 3. (c) Social Security No. 499-10-1122

4. Sex Male 2 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
About 50

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Alvin K. Burris  
 (b) Address 927 E. 18th St.

17. (a) Burial (b) Date thereof 4-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director Patricia Ann Smith  
 (b) Address 1729 Lydia

19. (a) 4-18-46 (b) Esteradine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 44  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1808 1/2 Forest  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
 year 1946 hour 1 minute 45 P.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 Hypertensive Heart Disease  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to Alcoholism

Other condition Same as above  
(Include pregnancy within 3 months of death)

Major findings: 93 D  
 Of operations \_\_\_\_\_  
 Of autopsy No Permit

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 Deputy Coroner  
 Signature Phyllis Williams (M. D. or other)  
 Address 2636 Brookley Date signed \_\_\_\_\_

*Case*

**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.....

*Lawrence A. Jones*  
working under my personal supervision.

Registered Apprentice No. *378*

Signed *J. J. Manlove*

Licensed Embalmer No. *3994*

P. O. Address *2503 High*

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

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

**MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

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1808 1/2 Forest  
(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..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME William Burris

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

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

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

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

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER { 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 (b) Date thereof 4-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-18-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 5  
 year..... hour..... minute..... M.

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

Due to.....

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(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.....

**SUPPLEMENTARY**

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

13000