

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

9-2
5-43
17-39
X36671
FILED AUG 27 1946
Registration District No. 77

Primary Registration District No. 3016

State File No. _____
Registrar's No. 195

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hospital 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 Days
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26
(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 215 E. Dunklin 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John Henry Burton

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

4. Sex Male 5. Color or race Negro
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 23 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 7 16 hr. _____ min.

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

10. Usual occupation Retired Postal Employee

11. Industry or business U.S. Post Office

12. Name John H. Burton

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

14. Maiden name Mildred Ann Streets
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mary Lee Scott

(b) Address 215 E. Dunklin, J.C. Mo.

17. (a) Burial (b) Date thereof 8-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lanovien

18. (a) Signature of funeral director John Lewis

(b) Address 700 1/2 Ave. 95 4th

19. (a) 8-19-46 (b) R. O. Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9 11
year 1946 hour 4 minute 15 A. M.
21. I hereby certify that I attended the deceased from July 13
1946 to Aug 9 1946
that I last saw him alive on Aug 9 1946
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial
Due to age infarction
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Cystitis
Of operations: _____
Of autopsy: none
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) CRIO
(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 Elio Wagner (M. D. or other) _____
Address Jefferson City Mo Date signed 8-10-46

RECEIVED
District Health Officer No. 9,
District File Number 8-24-208
Date Filed 8-24-16

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 J. M. Anderson

Licensed Embalmer No. 3641

P. O. Address J. M. Anderson

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.

Registration District No. 77 Primary Registration District No. 3016

1. PLACE OF DEATH:
(a) County cole
(b) City or town Jefferson city
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME John H. Burton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Dec 23 1904
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days MO If 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 Dec Day 23 Year 1951 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to chronic Rheumatoid 24/61
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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