

FILED FEB 5 1947

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 160

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Carrollton
 (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 66 yrs. (Specify whether)
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
 (c) City or town Carrollton
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ANDREW E BURNER

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife Blanche Burner 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased Dec 21 1878
 (Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Farming

12. Name Andrew J. Burner

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

14. Maiden name Ann Jane Howell

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

16. (a) Informant Mrs Andrew Burner

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 1-26-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem Standley Gibson

18. (a) Signatory of funeral director Carrollton Mo
 (b) Address Carrollton Mo

19. (a) 1/25/47 (b) Mrs Verber
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1947 hour 1 minute 350 M.
 21. I hereby certify that I attended the deceased from Jan 1 to Jan 24 1947
 that I last saw him alive on Jan 24 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis + pneumonia
 Duration 6 mos. yrs.?

Due to _____
 Due to _____

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

Major findings: Of operations _____
 Of autopsy _____
 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: REQUESTED

(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 _____

Signature W. Hamilton Stuten (M. D. or other) 1/26/47
 Address Carrollton, Mo. Date signed 1/26/47

RECEIVED

District Health Officer No. 8,

District File Number

Filed

1-31-47

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.....

Ben W. Gibson

Licensed Embalmer No.....

2961

P. O. Address.....

Carrollton

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 727
Registrar's No. 160-7

Registration District No. 55

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County: Carroll
(b) City or town: Carrollton
(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: Andrew E. Burner

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

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

6. (b) Name of husband or wife: Blanche 6. (c) Age of husband or wife if alive: _____ year

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

8. AGE: Years 68 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 FATHER

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) Andrew E. Burner (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 July Day 24 Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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: J.B. of lungs

asthma, heart exhaustion

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.

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

S-505