

FILED JAN 30 1947

State File No.

Registration District No. 160

Primary Registration District No. 5231

Registrar's No.

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Montevilla, Mo. Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 4 yrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Jesse M. Burgess

3. (b) If veteran,

name war

3. (c) Social Security

No. 702-07-7730

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mrs. Grace Burgess
6. (c) Age of husband or wife if alive. years 9
7. Birth date of deceased Aug 9 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 4 29 hr. min.

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

10. Usual occupation Retired R.R. man

11. Industry or business Frisco R.R.

12. Name Jerry Burgess

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

14. Maiden name Ellen Matt

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

16. (a) Informant Grace E. Burgess

(b) Address 600 Quads Springs Mo.

17. (a) Burial (b) Date thereof 1 12 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clintonville

18. (a) Signature of funeral director Lucian Carothers

(b) Address Clintonville Mo.

19. (a) 1-14-47 (b) Mrs. Velma Ellis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
(c) City or town Montevilla, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R. 1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 8
year 1947 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Dec. 13, 1946, to Jan 8, 1947;
that I last saw him alive on Jan 8, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death

Angina Pectoris

Due to Cordial Muscles

Due to inflammation

Due to Thrombosis

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?

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

23. Signature L. B. Baunister (M. D. or other)

Address Clintonville Mo. Date signed 1-8-47

383

(Licensed Embalmer's Statement on Reverse Side)

JAN 30 1947

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 *Floyd E. Carstensen*
Licensed Embalmer No. *4419*
P. O. Address *El Dorado Springs*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 7-1Registration District No. 60Primary Registration District No. 5235

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Cedar
(b) City or town 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 _____
years, months or days

3. (a) PRINT
FULL NAME

- (b) If veteran, Jesse M. Burger 3. (c) Social Security
name war _____ No. _____

4. Sex m 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 _____

7. Birth date of deceased aug 9
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 20 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 2-6-47 (b) Mrs. Velma Ellis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State mo (b) County Cedar
(c) City or town Montevallo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
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 _____

- Due to _____

- 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)
(c) Means of injury _____

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

- Address _____ Date signed _____

Duration _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

S-536