

No. 2
-2-43
-17-39
X35697

FILED JAN 29 1948

State File No. _____

Registration District No. 370

Primary Registration District No. 6151

Registrar's No. 5

1. PLACE OF DEATH

(a) County Stoddard

(b) City or town Essex MO (Elk)

(c) Name of hospital or institution: None

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Essex MO

(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ROGER DALE BURNETT

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4 year 1948 hour 2 minute 150 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex M.

5. Color or race White

6. (a) Single, widowed, married, divorced Div.

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Dec. 28 (Month) (Day) (Year) 47

that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Investigation shows pneumonia Duration ✓

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

Due to _____

Due to _____

9. Birthplace Essex MO (City, town, or county) (State or foreign country) 0

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

10. Usual occupation ✓

Major findings: Of operations _____

11. Industry or business _____

12. Name Charles B. Burnett

13. Birthplace Berrie MO (City, town, or county) (State or foreign country) 0

Of autopsy _____

PHYSICIAN _____

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

14. Maiden name Edna Hiten

15. Birthplace Como MO (City, town, or county) (State or foreign country) 0

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? _____

16. (a) Informant Charles B. Burnett

(b) Address Essex MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5-48 (Month) (Day) (Year)

(c) Place: burial or cremation Barker Cemetery

(Specify type of place) _____ (e) Means of injury ✓

23. Signature Dexter (M. D. or other) Co.

18. (a) Signature of funeral director Walter Thomas Swier

(b) Address Parma MO

19. (a) 1/20-1948 (Date received local registrar) (b) Leticia J. J. J. (Registrar's signature) 257

Address Dexter, Mo. Date signed 1-5-48

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

RECEIVED
District Health Office No. 2,
District File Number 148-152
Date Filed 1-27-48

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: Eymond Steele

Licensed Embalmer No. 2476

P. O. Address District No.

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. *340*

Primary Registration District No. *6151*

Registrar's No. *5*

1. PLACE OF DEATH

(a) County *Stoddard*
(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 *Roger D. Burnell*

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 *S*

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 _____

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 _____ day _____ year *1948* 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 *from information received from patient present before death and at the time of death, it must have been bronchial pneumonia*
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 *Alexander Coroner* _____ (M.D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

1948
S-3685