

FILED JUL 8 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18661

State File No.

Registration District No. 32

Primary Registration District No. 5710

Registrar's No. 50

## 1. PLACE OF DEATH:

- (a) County Ballinger Co.  
(b) City or town Filmore  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1

(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 Betty Burns

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced wid-wed  
6. (b) Name of husband or wife Thomas Burns 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Aug. 31 1853  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
95 10 11 12 hr. min.

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

10. Usual occupation Wife

## 11. Industry or business.

12. Name George Rhodes  
13. Birthplace Buckeaton (State or foreign country)  
14. Maiden name Burns  
15. Birthplace Buckeaton (State or foreign country)

16. (a) Informant Joe Miller  
(b) Address Glen Allen  
17. (a) Burial (b) Date thereof 7-24-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation university home  
18. (a) Signature of funeral director John E. Kende

- (b) Address Lebanon  
19. (a) June 30/48 (b) William Vandenberg  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Ballinger  
(c) City or town Filmore  
(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 May day 14  
year 1948 hour 12 minute a M.

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

that I last saw h. c. t. alive on 3/11/48 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration

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) (c) Means of injury.

23. Signature John J. Myers (M. D. or other)  
Address Lebanon Mo. Date signed 6/1/48

RECEIVED

Health Officer No. 4

File Number 748-86

Dated 2-2-48

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**