

No. 2
8-49
17-34
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FILED AUG 11 1948

Registration District No. 47

Primary Registration District No. 3008

State File No. 22361

Registrar's No. 230

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

1. PLACE OF DEATH:

(a) County Callaway County
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 yrs 5 m 24 d
(Specify whether) 2
In this community 22 yrs 5 m 24 d
years, months or days

3. (a) PRINT FULL NAME CORA BURNS

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

4. Sex Female 5. Color or race W. Whit 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. N. J. Burns 6. (c) Age of husband or wife if alive DK years

7. Birth date of deceased. DK (Month) DK (Day) 1869(?) (Year)

8. AGE: Years 79(?) Months DK Days DK If less than one day hr. 0 min. 0

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name DK

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

14. Maiden name DK

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

16. (a) Informant Resident at State Hospital

(b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof Aug 8 - 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boone Co

18. (a) Signature of funeral director R. E. Wierth

(b) Address Columbia

19. (a) Aug 8, 1948 (b) Jesse M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Clark
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5th
year 1948 hour 9:00 minute P M.

21. I hereby certify that I attended the deceased from 11 June
1948, to 5 August, 1948;
that I last saw him alive on 5 August, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

Due to _____

Due to _____

Other conditions Fractured femur, Lower
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 10/10

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? 14

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature Dr. Milton M. O. (M. D. name)
Dr. Wayne ... Date signed Aug 5, 1948

Address State Hospital No. 1 Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statelically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed

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

Ruxess

Licensed Embalmer No.

3183

P. O. Address

Columbia

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. aug
Registrar's No. 230

Registration District No. 47

Primary Registration District No. 3009

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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 Core Burn

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

4. Sex F 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 _____ (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ (If less than one day, hr. min.)

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

MOTHER FATHER

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 _____ Year 194 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 _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 5 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) Accident
(b) Date of occurrence Don't know
(c) Where did injury occur? State Hospital No 1 (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 Fulton (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

7-10-48

S-22361