

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 8 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Days
In this community 20 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 701 W. Scott
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas F. Burns Sr.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Shirley B. 6. (c) Age of husband or wife if alive Dec. 1863
7. Birth date of deceased July 24 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 3 18 hr. min.

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

10. Usual occupation Retired

11. Industry or business Engineer

12. Name Frank Burns

13. Birthplace Albany New York
(City, town, or county) (State or foreign country)

14. Maiden name Bussen

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

16. (a) Informant Tom Burns Jr.

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov 5 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 11-5-48 (b) W.E. Hensley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 2
year 1948 hour 11 minute 50p. M.

21. I hereby certify that I attended the deceased from Oct. 22, 1948, to Nov. 2, 1948
that I last saw him alive on Nov. 2, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary-Renal-Vascular Disease
Duration 5 yrs.

Due to _____
Due to _____

Other conditions Fracture of Rt. Hip
(Include necrosis within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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 133

(b) Date of occurrence Oct 22, 1948

(c) Where did injury occur? Springfield Greene Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place) (e) Means of injury Fall

23. Signature W.E. Hensley M.D. (M. D. or other) M.D.

Address Springfield, Mo. Date signed 11-4-48

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

MOTHER FATHER

JAN 31 1949

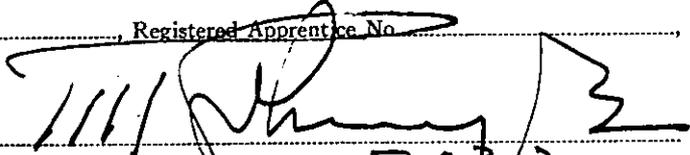
STATEMENT BY LICENSED EMBALMER

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.

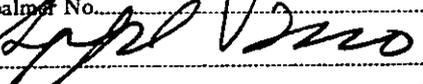
Signed.....



Licensed Embalmer No.

203/3

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.