

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27913

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7019

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) Robertsville, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, (1)		d. STREET ADDRESS (If rural, give location) NR	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) William			b. (Middle) H			
c. (Last) Burris			August 10, 1949			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 8/3/1879	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 7 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri (1)		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Nesbit Burris	13b. MOTHER'S MAIDEN NAME Rosalie E. Remon	14. NAME OF HUSBAND OR WIFE Lola Burris, Robertsville, Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Lola Burris, Robertsville, Mo.	
		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Superior Mesenteric Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac fibrillation mixed thrombosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Generalized Gangrene of intestine.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 99	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 578X	

22. I hereby certify that I attended the deceased from August 10, 1949, to August 10, 1949, that I last saw the deceased alive on Aug. 10, 1949, and that death occurred at 9:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE F.R. Bradley, M.D.		23b. ADDRESS Barnes Hospital		23c. DATE SIGNED 8/10/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/10/49	24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill one	24d. LOCATION (City, town, or county) (State) Villa Ridge, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 11 1949		25. FUNERAL DIRECTOR'S SIGNATURE Casey & Russell, St. Clair, Mo.		

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed David Russell

Licensed Embalmer No. 4820

P. O. Address St. Clair, Ind

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.