

FILED JUL 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23062**

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **89**

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY OR TOWN Harrisonville		c. CITY OR TOWN Harrisonville	
c. LENGTH OF STAY (In this place) 90 yrs		d. STREET ADDRESS 604 E. Mechanic	
d. FULL NAME OF HOSPITAL OR INSTITUTION 604 E. Mechanic			

3. NAME OF DECEASED (Type or Print) ALLIE DEACON BURNEY			4. DATE OF DEATH (Month) (Day) (Year) July 5 1956		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female		6. COLOR OR RACE White		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept 15 1864		9. AGE (In years last birthday) 91		10. IF UNDER 18: Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or when retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Brighton, Ontario Canada		12. CITIZEN OF WHAT COUNTRY USA	
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13a. OTHER NAME John B. Deacon		13b. MOTHER'S MAIDEN NAME Flavia Proctor		14. NAME OF HUSBAND OR WIFE W. L. P. Burney	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME Ruth B. Pearson ADDRESS Harrisonville, Mo.	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH immediate ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **May**, 1953, to **July 1**, 1956, that I last saw the deceased alive on **July 1**, 1956, and that death occurred at **7 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edward S. Jones MD.		23b. ADDRESS Harrisonville Mo		23c. DATE SIGNED 7-7-56	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 9 1956		24c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		24d. LOCATION (City, town, or county) (State) Harrisonville Mo	
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DATE RECD BY LOCAL REG. July 7, 1956		REGISTRAR'S SIGNATURE Doro Barraud		FUNERAL DIRECTOR'S SIGNATURE Pannenburg ADDRESS Harrisonville Mo	
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WRITE PLAINLY—USING UNFADING 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

James R. Phillips

Licensed Embalmer No. *4641*

P. O. Address *Harrisonville, Mo.*

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.