

FILED APR 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11966

State File No. ....

|   |                               |   |   |  |
|---|-------------------------------|---|---|--|
| BIRTH NO. ....  |                               | REG. DIST. NO. <u>42</u>  | PRIMARY REG. DIST. NO. <u>1000</u>  | Registrar's No. <u>432</u>   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BUCHANAN</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>DEKALB</u>  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>St. JOSEPH</u>   |                               | c. LENGTH OF STAY (In this place)<br><u>4 DA</u>  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>AMITY (RURAL) 0320</u> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>MERCY HOSPITAL</u>  |                               | d. STREET ADDRESS (If rural, give location)<br><u>1</u>   |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>THOMAS</u> b. (Middle) <u>LEWIS</u> c. (Last) <u>BURRIS</u>   |                               | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>APRIL 5 1950</u>  |   |  |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>  | 8. DATE OF BIRTH<br><u>APRIL 10-1866</u>  | 9. AGE (In years) (last birthday) <u>84</u><br>If under 1 year: Months _____ Days _____<br>If under 2 hrs.: Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><u>DEKALB Co. Mo</u>   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |
| 13a. FATHER'S NAME<br><u>LILBURN BURRIS</u>   |                               | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>AMANDA BURRIS</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>✓✓</u>  | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS<br><u>Th. Burris 1017 Grand St. St. Joseph Mo</u>           |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Senility</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 DAYS</u><br><br><u>331X</u>   |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION<br><u>✓</u>  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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)   |  |
| 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?  |  |
| 22. I hereby certify that I attended the deceased from <u>4-1-</u> 19 <u>50</u> to <u>4-5-</u> 19 <u>50</u> , that I last saw the deceased alive on <u>4-5-</u> 19 <u>50</u> , and that death occurred at <u>5:30 A</u> m., from the causes and on the date stated above. |                               |   |   |  |
| 23a. SIGNATURE<br><u>Dr. S. J. ...</u>  |                               | 23b. ADDRESS<br><u>823 FARRON ST.</u>   | 23c. DATE SIGNED<br><u>4-5-50</u>   |  |
| 24a. BURIAL CEMETERY (If 24b. DATE OF REMOVAL (month) (day) (year)<br><u>MAKESVILLE MO 4-5-1950</u>   |                               | 24c. NAME OF CEMETERY OR CREMATORY<br><u>CLARKSDALE CEM.</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>CLARKSDALE MO</u>  |
| DATE REC'D BY LOCAL REG.<br><u>April 5, 1950</u>  |                               | REGISTRAR'S SIGNATURE<br><u>E. C. Jenkins 382</u>   | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS<br><u>FILCHER FUNERAL HOME, MAKESVILLE MO</u>                |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

MAY 26 1950

MAN 11357

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate *will be* was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*[Handwritten Signature]*

Licensed Embalmer No. *3960*

P. O. Address *Maple Hill, 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.