

Banta

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36049

1. PLACE OF DEATH

County HenryRegistration District No. 367

File No.

Township LinsellePrimary Registration District No. 5501 C

Registered No.

City Coal Mt. Rest 4 (No.)

St. Ward)

2. FULL NAME

Sally Melinda Burrus

(a) Residence. No. St.

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Huston Burrus

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

NOV 11 1869

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

54 -1 -4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Samuel Harding

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dont Know

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dont Know

PARENTS

14. INFORMANT

(Address)

H. Burrus
Clinton, Mo.

15. FILED

Dec 20 1923C. B. Banta

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 6 1923

17.

I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1923, to Dec. 6, 1923.
that I last saw h. s. a. alive on Dec. 6, 1923, and that death occurred, on the date stated above, at 5 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

diabetes mellitus

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

C. B. Banta

M. D.

, 19 (Address)

Coal, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Farko Chapel12/8 1923

20. UNDERTAKER

ADDRESS

Sam. McKinnon Co. Clinton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
Towship..... Primary Registration District No..... Registered No.....
City..... (No.....) St..... Word.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (enter the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from that I last saw h. alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19 ADDRESS

20. UNDERTAKER