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

Do not use this space.

32545

1. PLACE OF DEATH
County Vernon — Registration District No. 875 — File No.
Township Whiskey — Primary Registration District No. 6162 — Registered No. 171
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Sophia Burmaster
(a) Residence. No. State Hosp St., ... Ward. .....
(Usual place of abode) Nevada Mo (If nonresident give city or town and State)
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: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): D 18

7. AGE: YEARS 2 — MONTHS 1 — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): D 1 2
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: D 1 2
11. BIRTHPLACE OF FATHER (CITY OR TOWN): D 1 2
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: D 1 2
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): D 1 2
(STATE OR COUNTRY)

14. INFORMANT: Fred Burmaster
(Address): Jerico Springs

15. FILED 10/26 1927 E. R. Kiess
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10 – 18. 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1927, to 10 – 18, 1927, that I last saw her alive on 10 – 18, 1927, and that death occurred, on the date stated above, at 6 15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis
23A
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 37
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? D 1 2
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Ls B Darrell M. D
10 – 26 1927 (Address) Nevada 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: State Hosp — DATE OF BURIAL: 10 – 28 1927

20. UNDERTAKER: Allen W. Hays — ADDRESS: Nevada

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