

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

Do not use this space.

33518

File No. _____
Registered No. 789
St. _____ Ward _____

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township _____ Primary Registration District No. 2001
 City Springfield (No. 845) Weaver St. _____ Ward _____

2. FULL NAME James Burns
 (a) Residence No. 845 Weaver St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 27-1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>63</u>	<u>10</u>	<u>6</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work faritor
 (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 Alex Burns

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

12. MAIDEN NAME OF MOTHER Ferba Burns

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

14. INFORMANT Mabel Brown
 (Address) 845 Weaver

15. FILED 10-31-19-29 Low Sharp REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 29th 1929

17. I HEREBY CERTIFY That I attended deceased from July 21st, 1929, to Oct. 29th, 1929, that I last saw him alive on Oct. 28th, 1929, and that death occurred, on the date stated above, at 7:41 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

57A Hypertensive Arteritis
52A (duration) _____ yrs. 4 mos. _____ da.
 CONTRIBUTORY Exhaustion
 (SECONDARY) (duration) _____ yrs. 1 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) N. S. Hunter, M. D.
Oct. 30, 1929 (Address) 328 1/2 Bowditch

*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 Hazelwood Cem DATE OF BURIAL Nov 29

20. UNDERTAKER J. P. Campbell ADDRESS 869 Wash

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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5-2-29

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11/11/11

11/11/11