

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

Do not use this space.

34042
4495

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

1. PLACE OF DEATH

County of Jackson Registration District No. 399
Township Kansas Temporary Registration District No. _____
City Kansas City (No. General Hospital #2) St. _____ Ward _____

2. FULL NAME

Annie Burris
(a) Residence. No. 529 Lacey St. 1 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 33 yrs. . mos. . ds. How long in U. S., if of foreign birth 46 yrs. . mos. . ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1869</u>		
7. AGE YEARS <u>60 yrs</u>	MONTHS	DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>109</u> (c) Name of employer		

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

10. NAME OF FATHER Charlie Jenkins

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

12. MAIDEN NAME OF MOTHER Lizzie Eddins

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

INFORMANT Record of the Registrar
(Address) 529 Lacey St. Hosp #2

15. FILED 10/31, 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 30, 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1929 to Oct 30, 1929 that I last saw him alive on Oct 30, 1929, and that death occurred, on the date stated above, at 6:40 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
(1) Pneumonia (bacterial)
Phagocytic myocarditis
Syphilitic aortitis.
(duration) ? yrs. . mos. . ds.

CONTRIBUTORY (SECONDARY) 28
(duration) _____ yrs. . mos. . ds.

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

6. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. M. Smith, M. D.
10/31, 1929 (Address) Gen Hosp #2

*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 Glasgow Mo DATE OF BURIAL Nov 1, 1929

20. UNDERTAKER Tommy Hillen ADDRESS Glasgow Mo

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

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.

