

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.

REC'D MAY 10 1939

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

13825
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Frank Primary Registration District No. 1002
 (c) City St. Charles (d) Street No. 18 E. Gen. Hosp. Registered No. 1579 St.
 (1 death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Burris, Edmoide W
 (a) Residence, No. 2709 Summit St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Mary Burris
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April - 20 - 1880
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 58 11 23
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Conductor R.R.
 9. Industry or business in which work was done, as saw mill, bank, etc. Conductor R.R.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MD.
 FATHER 13. NAME E. B. Burris
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 MOTHER 15. MAIDEN NAME Julia Monte
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MD.
 17. INFORMANT (ADDRESS) Richard Clark
18 E. Gen. Hosp.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Elmwood DATE 4/17 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. S. Foust
918 B. 2005 St.
 20. FILED Apr 15 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 - 13 - 39
 22. I HEREBY CERTIFY, That I attended deceased from 4 - 8 - 39, 1939, to 4 - 13 - 39, 1939.
 I last saw deceased on 4 - 13 - 39 Death is said to have occurred on the date stated above, at 11:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Coronary sclerosis Date of onset _____
with occlusion
94B
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) P. DeMarian M. D.
 (Address) St. Charles, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address 918 Brooklyn

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, above space should be left blank.