

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

14744
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 238
 (b) Township Lockwood, Mo Primary Registration District No. 5024
 (c) City Lockwood, Mo (d) Street No. 4115 Registered No. _____
 (e) Length of residence in city or town where death occurred _____ mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 18, 1940

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

22. I HEREBY CERTIFY That I attended deceased from June 18, 1940, to June 18, 1940
 Last saw him alive on June 18, 1940. Death is said to have occurred on the date stated above, at about 4 PM,
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 15, 1871
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
68 10 3

Asphyxiated from fumes from his car while running in his garage with door closed.
 Date of onset _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Spanish War Veteran
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede, Mo

FATHER 13. NAME Wm Burnett

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn

MOTHER 15. MAIDEN NAME Anna Gentry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn

17. INFORMANT (ADDRESS) Ella Burnett
Lockwood, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lockwood DATE Jun 20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ray Caldwell
Lockwood, Mo

20. FILED K-20 1940 J. A. Wren
Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis Permatone Was there an autopsy? no

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) J. A. Wren, M. D.
Lockwood, Mo
 (Address) _____

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

195-
88

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 14 744

Registration District No. 238

Primary Registration District No. 4145

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Lackwood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Samuel Burnett

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 10 3 _____ min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U.S.A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jun day 18 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death asphyxiated
from fumes from gas
while running in his
garage with door
closed

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death) 2/19 11/4

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence _____

(c) Where did injury occur?: (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature James A. Wren (M.D. or other) _____

Address Lackwood Mo Date signed _____

SUPPLEMENTAL

S-14744