

Registration District No. 400

Primary Registration District No. 55538

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Jackson Prairie Mo
(b) City or town J. C. Horn
(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 3
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME Byron M. Burns 652

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Innocent (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 5 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 25 If less than one day hr. _____ min. _____

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

10. Usual occupation Salesman

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ernest Jackson

(b) Address J. C. Horn

17. (a) Removal (b) Date thereof Apr 3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kingsville Feb 06 07

18. (a) Signature of funeral director Ketter

(b) Address A 6 Hwy 932

19. (a) 4-6-40 (b) Earl A. Gaines
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town J. C. Horn
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 30
year 1940 hour 7:20 minute 0 P. M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to 3-30 1940
that I last saw him alive on 3-29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute regurgitation

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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 J. H. Green (M. D. or other) _____
Address W. Green Date signed 4/3-40

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

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 comply the above constitutes grounds for revocation of license.)

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