

13-40
7-39
156

12 1941

Registration District No. 347

Primary Registration District No. 3079

Registrar's No. 163

1. PLACE OF DEATH

(a) County Marion
(b) City or town Hannibal
(c) Name of hospital or institution: St. Elizabeth Hosp'l
(d) Length of stay: In hospital or institution wk.
In this community _____ years, months or days

3. (a) PRINT FULL NAME William P. Burgess

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 Lula 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased June 13 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Delhi / Ill
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Robert T. Burgess
13. Birthplace Paris / Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Eleanor Watson
15. Birthplace Vermont / Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Burgess
(b) Address 827 S Arch Hannibal Mo

17. (a) Burial (b) Date thereof April 17-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cem

18. (a) Signature of funeral director James O'Connell
(b) Address Hannibal Mo

19. (a) 5-24-41 (b) H. C. Gisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion Co
(c) City or town Hannibal 3
(d) Street No. 827 S Arch 4
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1941 hour _____ minute 5:55 a.m.

21. I hereby certify that I attended the deceased from Mar 29, 1941 to April 15, 1941 that I last saw him alive on April 15, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma Duration 7-8 weeks

Due to Myocarditis

Due to Influenza

Other conditions _____ (Includes pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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? Yes

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. B. Hillman (M. D. or other) MD
Address 306 Broadway Date signed 5-2-41

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: *Michael J. Alfonso*

Licensed Embalmer No. *3244*

P. O. Address *Anniston, Ala*

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, fact should be so stated above.