

DEC 23 1941 637

Registration District No.

Primary Registration District No.

6084

Registrar's No.

1. PLACE OF DEATH

(a) County Shannon
(b) City or town Rural Jackson Twp
(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 Shelvy-Dora Burris

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Aug 2 - 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 17 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Shelvy D. Burris

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

14. Maiden name Berta May Kelley

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

16. (a) Informant Mrs Kelley

(b) Address Reister Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 - 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Bethel Chapel

18. (a) Signature of funeral director none

(b) Address _____

19. (a) 10-26-41 (Date received local registrar) (b) Frank Boyd Mo (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon 101
(c) City or town Rural Jackson Twp 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1941 hour 10 minute 45 P.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 Bubero Esclatris Duration
Johns Neander

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1190

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) _____

(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 Frank Boyd (M. D. or other) _____

Address Quincy Mo Date signed 10-26-41

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

RECEIVED

District Health Officer No. 5,

District File Number 12462085

Date Filed

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.