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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41078

State File No. 4758

Registrar's No.

Registration District No. 24 1942 399

Primary Registration District No. 1002

48  
3  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Jackson  
(a) County: Jackson  
(b) City or town: Kansas City Mo.  
(c) Name of hospital or institution: St. Marys Hospital.  
(d) Length of stay: In hospital or institution: 4 1/2 Yrs. 0  
In this community: 4 1/2 Yrs. 0

3. (a) PRINT FULL NAME: Theresa Murphy BURNS.

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

4. Sex: Female  
5. Color or race: White  
6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife: Dennis P. Burns  
6. (c) Age of husband or wife if alive: 1864

7. Birth date of deceased: January 14th, 1864

8. AGE: 77 Years, 11 Months, 7 Days

9. Birthplace: Wisconsin At Home

10. Usual occupation: At Home

11. Industry or business: John Murphy.

12. Name: John Murphy.  
13. Birthplace: Ireland

14. Maiden name: Curia Walsh.  
15. Birthplace: Burlington Vermont.

16. (a) Informant: Frank J. Murphy.  
(b) Address: 5018 Forest Ave.

17. (a) Removal: (b) Date thereof: 12/23/41  
(c) Place: burial or cremation: Creston Iowa.

18. (a) Signature of funeral director: Meliody-McGilley.  
(b) Address: K. C. Mo.

19. (a) Date received local registrar: Dec 22 1946  
(b) Registrar's signature: M. M. Brown

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Jackson  
(c) City or town: Kansas City Mo.  
(d) Street No.: 3935 Harrison Ave.  
(e) If foreign born, how long in U. S. A.: 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: December day: 21  
year: 1941 hour: 11 minute: 0 P. M.

21. I hereby certify that I attended the deceased from: 12-15, 1941, to: 12-21, 1941.  
that I last saw her alive on: 12-21, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral embolism  
Duration: Cerebral embolism

Due to:  
Due to:

Other conditions: f3c  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations:  
Of autopsy: yes

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?:  
(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: A. A. Quipus (M. D. or other)  
Address: 1034 Rector Date signed: 12-22-41

**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. 2925

P. O. Address..... TC

**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.**

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STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....  
Registrar's No. 4758

Registration District No. .... Primary Registration District No. ....

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution: St. Marys Hosp  
(If outside city or town limits, write "RURAL" and name of township)  
(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 Theresa M. Burns

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

4. Sex fe 5. Color or race wh 6. (a) Single, widowed, married, divorced.....

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 77 Months Days If less than one day hr. 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..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 120/41 N. M. Crowe

19. (a) (Date received local registrar) (b) (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. 3935 Harrison (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years

20. DATE OF DEATH: Month Dec day 21 year 1942 hour..... minute..... M.

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

Immediate cause of death Cerebral sclerosis Cerebral thrombosis

Due to.....

Due to.....

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

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 ATH Owens (M. D. or other) MD

Address 1034 Rialto Date signed.....

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941  
S-41078