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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 24 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27266

Registration District No. 384 Primary Registration District No. 4227 Registrar's No. 64

1. PLACE OF DEATH:
(a) County HOWELL
(b) City or town WEST PLAINS (Twp)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CHRISTA HOGAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS (Specify whether years, months or days)
In this community THOMASVILLE, Mo. 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County OREGON 75 0 0
(c) City or town RURAL THOMASVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME JAMES IRVIN BURROUGHS

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 WIDOWED

6. (b) Name of husband or wife AMELIA BURROUGHS

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

7. Birth date of deceased Nov. (Month) 1, (Day) 1876 (Year)

8. AGE: Years 65 Months 8 Days 1 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name JOSEPH AARON BURROUGHS
13. Birthplace WARREN COUNTY, (City, town, or county) TENN. (State or foreign country)

MOTHER
14. Maiden name MARY CATHERINE ACREE
15. Birthplace WEAKLY COUNTY, (City, town, or county) TENN. (State or foreign country)

16. (a) Informant J.N. BURROUGHS
(b) Address WEST PLAINS, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof [redacted] (Month) (Day) JULY 5 1942 (Year)
WOODSIDE CEMETERY
(c) Place: burial or cremation THOMASVILLE, Mo.

18. (a) Signature of funeral director Hal Hollingsworth
(b) Address WEST PLAINS, Mo.

19. (a) 7-3-42 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1942 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 27, 1942, 19..., to July 2, 1942, that I last saw him alive on July 2, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Ruptured Appendix

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operation
Of autopsy

Duration

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

23. Signature [illegible] (Attending physician)
Address West Plains, Mo. Date signed 7-3-42

1125 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number
Date Filed

RECEIVED
District Health Officer No. 5,
District File Number
Date Filed

RECEIVED
District Health Officer No. 5
District File Number 842630
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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, M

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.