. S. No. 2
OM—5-42
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10043

Registration District No. 218 | Primary Registration District No. 3017 | Registrar's No. 38

1. PLACE OF DEATH:
(a) County: Cooper
(b) City or town: Boonville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Alec Van Ravenswaay Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 40 days (Specify whether years, months or days)
In this community: 40 days -

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Morgan
(c) City or town: Syracuse
(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:

3. (a) PRINT FULL NAME: George W. Burns
3. (b) If veteran, name war: No
3. (c) Social Security No. 500-10-7336
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: OLLIE BURNS
6. (c) Age of husband or wife if alive: 45 years
7. Birth date of deceased: MAY (Month) - 15 (Day) - 1888 (Year)
8. AGE: Years 54 | Months 10 | Days 7 | If less than one day ___ hr. ___ min.
9. Birthplace: MORGAN COUNTY (City, town, or county) - MO (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business: FARM
MOTHER FATHER
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: OLLIE BURNS
(b) Address: SYRACUSE MO.
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof: 3-22-43 (Month) (Day) (Year)
(c) Place: burial or cremation: SYRACUSE-MO
18. (a) Signature of funeral director: James E. Richards
(b) Address: Tipton Mo
19. (a) May-22-43 (Date received local registrar) (b) Dr Chas. Swap (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22 year 1943 hour ___ minute 6 p.m.
21. I hereby certify that I attended the deceased from Feb 11, 1943, to March 22, 1943, that I last saw him alive on March 22, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Addisons disease	4 months
Due to: disease of suprarenal glands	
Due to:	
Other conditions (Include pregnancy within 3 months of death): —	

Major findings:
Of operations: None
Of autopsy: No

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: Alec Ravenswaay (M. D. or other)
Address: Boonville Mo. Date signed 3-22-43

1088 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-2-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ will be embalmed by me, or by me, Registered Apprentice No. working under my personal supervision.

Signed Jennie E. Richards
Licensed Embalmer No. 12466
P. O. Address Tipton Ind.

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.