

S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11695

FILED APR 8 1943

Registration District No. 354

Primary Registration District No. 6198

Registrar's No. 21

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

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural Cass Texas
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 25 years

2. USUAL RESIDENCE OF DECEASED: 107

(a) State Missouri (b) County Texas

(c) City or town Rural Cass 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME DWIGHT DAVID BURROWS

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Jennie

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

7. Birth date of deceased October 31 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

88 4 17 hr. _____ min.

9. Birthplace Rome 1 New York
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer and minister

11. Industry or business

12. Name David

13. Birthplace unknown 1 New York
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown 1 New York
(City, town, or county) (State or foreign country)

16. (a) Informant Glen C. Burrows

(b) Address Hogans, Mo

17. (a) Burial (b) Date thereof 3 19 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tragle

18. (a) Signature of funeral director W. D. Elliott

(b) Address Houston, Mo

19. (a) 3-24-43 (b) Mrs. L. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th
year 1943 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from No attending physician 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: Myocardial Insufficiency

Due to Supposed to be

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92 lb

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 W. H. Hubbard (M. D. or other) _____

Address Houston, Mo Date signed 3-23-43

RECEIVED

District Health Officer No. 5, 8
District File Number 44320
Date Filed 4-6-43

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, above space should be left blank.