S. No. 2
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FILED JUL 15 19

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21738

State File No.

Registration District No. 170 Primary Registration District No. 5635 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Ladede
(b) City or town Phillipsburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Union Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 16 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ladede 53
(c) City or town Phillipsburg 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? Yes No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Dwaunza Burd

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

4. Sex F
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 20 1927
(Month) (Day) (Year)

8. AGE: Years 12 Months 11 Days 16 If less than one day hr. min.

9. Birthplace Dallas, Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation School Girl

11. Industry or business

FATHER
12. Name Guy Burd
13. Birthplace Dallas Mo 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Leoline Canster
15. Birthplace Dallas Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Guy Burd
(b) Address Phillipsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-43
(Month) (Day) (Year)
(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director [illegible]
(b) Address Buffalo Mo

19. (a) 7-5-43 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1943 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 4-11, 1943 to 6-6, 1943
that I last saw her alive on 6-6, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of bowels

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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 J. W. Lindsay (M. D. or other) MD
Address Conway Mo Date signed 6-21-43

1090

(Licensed Embalmer's Statement on Reverse Side)

Received JUL 6 1943

Laclede County Health Unit

File No. 6-43-87

Date Filed JUL 9 1943

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 Elyde Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo Mo.

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.