

FILED JUL 31 1945

Registration District No. 154

Primary Registration District No. 5575

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town RURAL KANSAS CITY - WASHINGTON
(c) Name of hospital or institution: 7724 WALNUT STREET
(d) Length of stay: In hospital or institution --
In this community 49 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY - RURAL
(d) Street No. 7724 WALNUT STREET
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME LEE SHIPMAN BURRIS

3. (b) If veteran, name war No
3. (c) Social Security No. 496-01-5700

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS LUCILLE BURRIS
6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased DEC 23 1875

8. AGE: Years 69 Months 7 Days 23
If less than one day hr. min.

9. Birthplace GEORGETOWN Ohio

10. Usual occupation BARTENDER

11. Industry or business KANSAS CITY CLUB

12. Name JAMES BURRIS

13. Birthplace HARRISON Co. OHIO

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN

16. (a) Informant H. E. BOYLE

(b) Address 4470 WEST 53 MISSION Ks.

17. (a) Burial (b) Date thereof July 18, 1945

(c) Place: burial of cremation Kansas City, Kansas

18. (a) Signature of funeral director D. H. Newcomer Sons

(b) Address 1401 Brush Creek Blvd. K.C. Mo.

19. (a) 7/17/45 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 15TH
year 1945 hour 2 minute 45 AM.

21. I hereby certify that I attended the deceased from May 1944 to July 15, 1945
that I last saw him alive on July 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis
Due to: Chronic Myocarditis 2 yrs.

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

Major findings: Of operations: Of autopsy: home
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?

23. Signature: Thomas P. ...
Address: 1103 Grand Ave. K.C. Mo.
Date signed: July 17, 1945

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

11-11
A
A. Annie G. Hedgcock

OCT 19 1945

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 Keith Collier
Licensed Embalmer No. 3632
P. O. Address Kansas City 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 449
Registrar's No. 55

Registration District No. 154 Primary Registration District No. 5575

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Tural Washington Ave
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Lee S. Burris
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Dec 23 1907
(Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ohio (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 7/17/45 (b) D. Annie G. Hodges
(Date received local registrar) (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. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

OCT 19 1945

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