

DEPARTMENT OF COMMERCE
HEALTH SERVICE
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36885

State File No. _____

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. AAAA

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
3411 Broadway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 Years (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME WILLIAM FRANK BURGESS

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Tillie Burgess

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased June 20, 1885
(Month) (Day) (Year)

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

61 4 20 hr. min.

9. Birthplace Olathe, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Retired General Yardmaster

11. Industry or business Union Pacific R. R.

12. Name William N. Burgess

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Mary J. Cantrall

15. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tillie Burgess

(b) Address 3411 Broadway, K. C. Mo.

17. (a) Burial (b) Date thereof 11-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 11-12-46 (b) Headline Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3411 Broadway
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-10-46 day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9-1-42 19____ to 11-10-46 19____;
that I last saw him alive on 11-8-46 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive cardiovascular disease 15 yrs.

Due to _____

Due to _____

Other conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Major findings: 93 d
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 William Owens (M. D. or other) _____

Address 2016 Grand Date signed 11-11-46

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

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

H. H. Linn (unclear)
Becker Bldg. #1034
3-4

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

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.