

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **40490**

FILED DEC 19 1946

Primary Registration District No. **1002**Registrar's No. **5045**

## 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:  
**GENERAL HOSPITAL NO. 2** **0**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **7 DAYS**  
 In this community **40 YRS.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MAUDE NELSON BURNS**

3. (b) If veteran, name war. **no** 3. (c) Social Security No. **none**

4. Sex **3 FEMALE** 5. Color or race **NEGRO**  
 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **OCTOBER - 1889**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>57</b>	<b>1</b>	<b>-</b>	hr. _____ min.

9. Birthplace **WICHITA KANSAS**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **LAUNDRESS**

11. Industry or business \_\_\_\_\_

12. Name **unknown** **9**

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

14. Maiden name **unknown** **9**

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

16. (a) Informant **MEDICAL RECORDS DEPT.**(b) Address **GENERAL HOSPITAL NO. 2**

17. (c) **Removal** (b) Date thereof **12-2-46**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **C.P. University**18. (a) Signature of funeral director **HTB Mobara**(b) Address **1820 E. 18th**

19. (a) **12-2-46** (b) **Gertrude Holme**  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** **48**  
 (c) City or town **KANSAS CITY** **33**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **1646 E. 22nd TERRACE**  
 (If rural, give location)  
 (e) Citizen of foreign country? **NO** (Yes or No)  
 If yes, name country **0**

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **24**,  
 year **1946** hour **5**: minute **10 P.** M.

21. I hereby certify that I attended the deceased from **NOVEMBER**  
**17**, 19 **46** to **NOVEMBER 24**, 19 **46**  
 that I last saw her alive on **11-24**, 19 **46**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **UREMIA** Duration **72-96 hrs**

Due to **HYPERTENSIVE HEART DISEASE WITH**  
**ARTERIOSCLEROSIS**

Due to \_\_\_\_\_

Other conditions **LATENT SYPHILIS**  
 (Include pregnancy within 3 months of death)

Major findings: **308**

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **0**

23. Signature **Frank Davis** (M. D. or other) **M.D.**  
 Address **GENERAL HOSPITAL NO. 2** Date signed **11/25/46**

**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.....

*H B Moore*

Licensed Embalmer No. *2410*

P. O. Address..... *1820 E 180*

**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.**