

No. 2
5-43
5-17-39
I X36671

FILED MAR 12 1947

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson City
(c) Name of hospital or institution: St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
In this community 14 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miller
(c) City or town Eldon - Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 114 Chestnut
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME Betty-Lou-Burris
3. (b) If veteran, name war none
3. (c) Social Security No. 7
4. Sex Female 5. Color or race White
6. (a) Single (widowed, married, divorced, MARRIED)
6. (b) Name of husband or wife Milo-Burris
6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased Feb 1 1926
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 27
year 1947 hour 11 minute 20 P.M.
21. I hereby certify that I attended the deceased from Jan 28
1947 to Feb 27 1947
that I last saw h.s.r. alive on Feb 27 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
21 0 26 — hr. — min.

Immediate cause of death Body
burns (3rd & 4th
of body surface.
Due to _____
Due to _____

9. Birthplace Keokuk Iowa
(City, town, or county) (State or foreign country)

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? _____

11. Industry or business Home

MOTHER, FATHER {
12. Name Grafton-Shrahn
13. Birthplace Keokuk Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Delta-Sullivan
15. Birthplace Carthage Ill
(City, town, or county) (State or foreign country)

PHYSICIAN
Underlying conditions which death may be charged stat-ally.
181
15
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant Milo Burris
(b) Address Eldon Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-2-47
(Month) (Day) (Year)

(c) Place: burial or cremation Tusculumbia-Con
23. Signature Reinold Taylor M.D. (M. D. M.D.)
Address Jefferson City Mo Date signed 3-1-47

18. (a) Signature of funeral director Keith McKays
(b) Address Eldon Mo
19. (a) 3-1-47 (Date received local registrar) (b) R. P. Burris M.D. (Registrar's signature)

(Specify type of place) (c) Means of injury 0
68 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3/11/47

APR 3 1947

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 M. Kaye
Licensed Embalmer No. 3998
P. O. Address Eldon 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.

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Cape Girardeau city
(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 Betty Lou Burns

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Feb 1 1906
(Month) (Day) (Year)

8. AGE: Years 21 Months 0 Days 0 (If less than one day, hr. _____ min. _____)

9. Birthplace Jones (City, town, or county) Iowa (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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 7 year 1947 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) accident
(b) Date of occurrence _____
(c) Where did injury occur? Home (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? yes (Specify type of place) _____ (e) Means of injury airway

23. Signature Green A. Taylor (M. D. or other) M.D.
Address Jefferson City Date signed 3-19-47

SUPPLEMENTARY

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

S-4361