

FILED NOV 21 1947  
Registration District No. **28**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **Greene**

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

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

(d) Length of stay: In hospital or institution **1 night**  
(Specify whether years months or days)

In this community **Native**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dade 29**

(c) City or town **Everton Mo. R. 0**  
(If outside city or town limits, write "RURAL")

(d) Street No. **0**  
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **REBA BURTON**  
**Reba Burton**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **white**

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

6. (b) Name of husband **Wilford Burton**

6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **5-9-1906**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>41</b>	<b>5</b>	<b>23</b>	hr. min.

9. Birthplace **Dade Co. Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Lee Cunningham**

13. Birthplace **Tenn. 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **Arlene Mae**

15. Birthplace **Dade Co. Mo. 0**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Willard Burton**

(b) Address **Everton Mo.**

17. (a) **Burials** (b) Date thereof **11-4-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place, burial or cremation **Shilo**

18. (a) Signature of funeral director **Maria Reiman**

(b) Address **Miller Mo.**

19. (a) **11-4-47** (b) **W. E. Handley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **2**  
year **1947** hour **7** minute **05 A.** M.

21. I hereby certify that I attended the deceased from **Nov 1**  
**1947**, to **Nov 2**, **1947**;  
that I last saw her alive on **Nov 1**, **1947**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid Hemorrhage** **36 hr**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **GBA**

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 **10**

23. Signature **H. P. Hoxey** (M. D. or other)

Address **Springfield, Mo** Date signed **11/2/47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

