DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 6 1948

Registration District No. 360

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 81973

Primary Registration District No. 6225

Registrar's No. 87

1. PLACE OF DEATH:

(a) County: Vernon

(b) City or town: Washington Twp rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital no. 3 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 yrs. 8 mo. 17 da. (Specify whether years, months or days)

In this community 7 yrs - 8 Mos - 17 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Dade

(c) City or town: Lockwood 29
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A.? ____ years. 1

3. (a) PRINT FULL NAME: Albert Burroughs.

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M 0

5. Color or race: W

6. (a) ~~Single, widowed, married~~, divorced: D 1

6. (b) Name of husband or wife: —

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

7. Birth date of deceased: 8 (Month) 29 (Day) 1884 (Year)

8. AGE: Years 63 Months 10 Days 26 If less than one day ____ hr. ____ min.

9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation: farming

11. Industry or business: ____

FATHER
12. Name: Olin Burroughs.
13. Birthplace: New York (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name: Sarah Gibson
15. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Records
(b) Address: State Hospital #3.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 28. 48 (Month) (Day) (Year)
(c) Place: burial or cremation: Kings Point

18. (a) Signature of funeral director: W. R. Allison
(b) Address: Greenfield, Mo.

19. (a) 6-26-48 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 25. year 1948 hour 155 minute A. M.

21. I hereby certify that I attended the deceased from 6-1- 1946 to 6-25- 1948 that I last saw him alive on 6-24- 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Meningo Vascular Syphilis	32 yrs.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: 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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: J. R. Bunch (M. D. or other)
Address: State Hospital #3 Date signed 6-25-48

(Licensed Embalmer's Statement on Reverse Side)

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

Washington
Mrs Cathern Yandle
3048 Washington

RECEIVED
District Health Officer No. 7
District File Number 6-48-7
Date Filed 7-3-48

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 Geo. Newcomb, Registered Apprentice No. 66 working under my personal supervision.

Signed W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.