

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

DEC 23 1930

1. PLACE OF DEATH

County Monroe
Township Ward
City California (No.)

Registration District No. 571
Primary Registration District No. 4935

File No. 36814
Registered No. 60
St. Ward)

2. FULL NAME

Alice Smith Burns

(a) Residence. No. California Mo. St. 3rd Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 22 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

April 28, 1858

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

70 6 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

California

(STATE OR COUNTRY)

10. NAME OF FATHER

J. J. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

England

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Elizabeth Sterling

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

New York

(STATE OR COUNTRY)

14. INFORMANT

J. W. Burns
(Address) California, Mo.

15. FILED

Nov 4, 1930

J. W. Burns
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Nov 20 1930

17.

I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1930 to Nov 20, 1930 that I last saw him alive on Nov 20, 1930 and that death occurred, on the date stated above, at 9 e.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Thrombus

CONTRIBUTORY (SECONDARY)

740 (duration) yrs. mos. 7 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Burns, M. D.

11/21, 1930 (Address) California, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

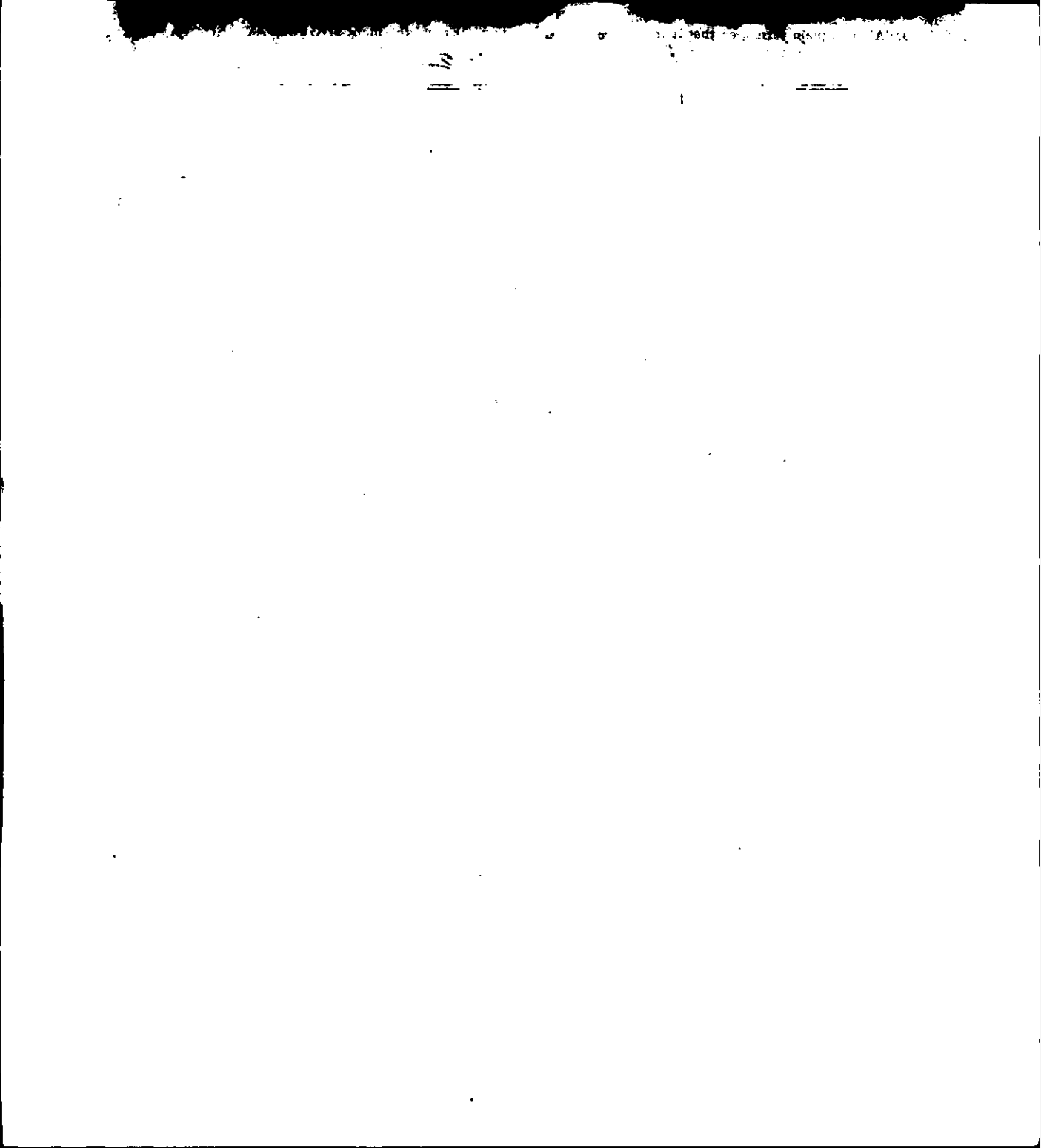
Catholic Cemetery Nov 22, 1930

20. UNDERTAKER

ADDRESS

J. W. Wilson & Son San California

N. B.—Every item of information supplied. Exact statement of cause of death in plain terms, so that it may be properly classified.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Moniteau
Township Paris
City Paris (No.)

Registration District No. 371
Primary Registration District No. 4335

File No.
Registered No. 60
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28 - 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 72 X 6 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED Nov 20 1930 Jas W Roth
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1930

17. I HEREBY CERTIFY That I attended deceased from
19....., 19.....
that I last saw h..... alive 19....., and that
death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. Information should be stated EXACTLY. PHYSICIANS should state CAREFULLY to properly certify a death.

LAW

PRESCRIBED

CERTIFICATES UNTIL

REGISTRAR

SUPPLEMENTARY

5368114