

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

Do not use this space.

11445

1. PLACE OF DEATH

County Licking
Township
City Chillicothe

Registration District No. 508
Primary Registration District No. 3026

File No. _____
Registered No. 44
St. _____ Ward)

2. FULL NAME Thornton Curry

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male | **4. COLOR OR RACE** Black | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 12, 1851

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
77	3	4	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

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

10. NAME OF FATHER Spencer Curry

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

12. MAIDEN NAME OF MOTHER Harriett Curry

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

14. INFORMANT Mrs. Thornton Curry
(Address) Chillicothe Mo

15. FILED 3/19, 1929 Reuben Barney
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 16, 1929

17. I HEREBY CERTIFY That I attended deceased from March 16, 1929 to March 16, 1929 that I last saw him alive on May 16, 1929, and that death occurred, on the date stated above, at 10:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
Concession of Barium

CONTRIBUTORY (SECONDARY) accident (Car)
auto

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

20. WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) R. M. Marshall, M. D.
3/18, 1929 (Address) Chillicothe, 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 With Colored Cemetery | **DATE OF BURIAL** 3/19, 1929

20. UNDERTAKER R. M. Marshall | **ADDRESS** Chillicothe, Mo.

Exact statement of OCCUPATION IS VERY IMPORTANT. Do not omit any details. Do not use this space.

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AUG 11 1942

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Livingston

Registration District No. 508

File No. _____

Township _____

Primary Registration District No. 3026

Registered No. 44

City Chillicothe (No. _____)

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 M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

(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) _____

PARENTS

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 5-17-1929 Reuben Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 16 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
Concussion of brain
15 hours
(duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Chillicothe - Livingston County
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? 1880
(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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-11445