DEC 20 1930

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

Do not use this space.

35424

File No. 1248

Registered No.

1. PLACE OF DEATH

County Buchanan Registration District No. 85

Township Primary Registration District No. 1001

City St Joseph Mo (No. 311 W. Kansas St. Ward)

2. FULL NAME Infant Mr & Mrs Wade Thurston

(a) Residence. No. 311 W Kansas 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 Fe

4. COLOR OR RACE Col

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18. 30

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, 2 hrs. or min.
0	0	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Joseph
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Wade Thurston

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

12. MAIDEN NAME OF MOTHER Anna Garman

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

14. INFORMANT Anna Thurston
(Address) 311 W. Kansas

15. FILED 19 John G. Wh
REGISTRAR

NOV 19 1930

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 18 1930

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 12:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth.

Months in utero Appx 7 mos. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

15 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS General Appearance

(Signed) G. Carrolans Hart M.D.

11/20. 1930 (Address) 207 1/2 W. Sno.

*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 City Cem

DATE OF BURIAL 11-19. 1930

20. UNDERTAKER B. F. Graves Funeral Home

ADDRESS 806 S. 17th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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