

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.

JUL 18 1936

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

Do not use this space.

22324

1. PLACE OF DEATH

County Clay Registration District No. 198  
Township Freshing River Primary Registration District No. 3611  
City Excelsior Springs (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

2. FULL NAME

Harry Thurston

(a) Residence, No. West Excelsior 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 <u>Male</u>	4. COLOR OR RACE <u>Collard</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 15 - 1921</u>		
7. AGE	YEARS	MONTHS
	<u>14</u>	<u>11</u>
		DAYS
		<u>21</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>In school</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Excelsior Springs Mo</u>		
13. NAME <u>Walter Thurston</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Versales Mo</u>		
15. MAIDEN NAME <u>Ruth Woods</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Jonesburg Mo</u>		
17. INFORMANT (ADDRESS) <u>Mrs Ruth Thurston Excelsior Springs Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Versales Mo</u> DATE <u>June 9 1936</u>		
19. UNDERTAKER (ADDRESS) <u>John C. Proffice Excelsior Springs Mo</u>		
20. FILED <u>6-1-1936</u> <u>Wm. R. McChesney Registrar</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 6 1936

22. I HEREBY CERTIFY, That I attended deceased from May 27 1936 to June 6 1936

I last saw him alive on June 6 1936 Death is said to have occurred on the date stated above, at 2:10 p.m.

The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia Right upper lobe

Date of onset May 29 1936

Other contributory causes of importance:  
Pneumonia was preceded by an influenza cold

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? ✓ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city, town, county, and State)  
Specify whether injury occurred in industry, home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) John F. Grace, M. D.  
(Address) Excelsior Springs Mo

Main body of the document containing the primary text, which is mostly illegible due to extreme blurriness and low contrast.

Handwritten or stamped text in the bottom right corner, possibly a signature or date.