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.

REC'D FEB 28 1939

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

4080
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard
(b) Township Pike
(c) City Bell City
Registration District No. 834
Primary Registration District No. 4506
Registered No. 6
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Marion Randolph Throower, Jr.
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: not married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Mar 23, 1918
7. AGE: 20 YEARS 10 MONTHS 13 DAYS; If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: None
9. Industry or business in which work was done, as 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): Bell City, Mo.

FATHER
13. NAME: Marion R. Throower, Sr.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bell City, Mo.

MOTHER
15. MAIDEN NAME: Anna Clark
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Carmi, Ill.

17. INFORMANT (ADDRESS): Mrs. Anna Throower, Bell City, Mo.
18. BURIAL, CREMATION, OR REMOVAL: PLACE Pleasant Grove DATE 2/6 1939
Stoddard Co. Mo.
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Bisplinghoff & Hobbs, Chaffee, Mo.
20. FILED 2-8 1939 D. S. McGee, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/5 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1939 to Feb. 5, 1939
I last saw him alive on 2/4, 1939. Death is said to have occurred on the date stated above, at 4:40 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Epilepsy	1934

Other contributory causes of importance:

Name of operation — Date of —
What test confirmed diagnosis? None 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 or town, county, and State)
Specify whether injury occurred in industry, in 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) O. O. Bennett, M. D.
(Address) Bell City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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, Mamie Bisplinghoff, or by .....

Registered Apprentice No. ....., working under my personal supervision.

Signed Mamie Bisplinghoff

Licensed Embalmer No. 3242

P. O. Address Chaffee M

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

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