

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.

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

12421  
 Do not use this space.

REC'D APR 21 1939

1. PLACE OF DEATH *W*

(a) County *Saline* Registration District No. *796*

(b) Township *1* Primary Registration District No. *3038*

(c) City *Marshall* (d) Street No. *104 E. Yerby* St.

(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 *360 THOMAS PIERCE VAWTER*

(a) Residence, No. *104 E. Yerby* St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Bessie Vawter</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Oct. 10, 1877</i>				
7. AGE	YEARS <i>61</i>	MONTHS <i>4</i>	DAYS <i>23</i>	IF LESS THAN 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>Retired</i>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <i>Merchant</i>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Marshall Missouri</i>			
	13. NAME <i>Thos. P. Vawter</i>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Callaway Co Mo</i>			
	15. MAIDEN NAME <i>Adeline Vaughn</i>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Kentucky</i>				
17. INFORMANT (ADDRESS) <i>Mrs. Bessie Vawter Marshall, Mo</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Ridge Park</i> DATE <i>Mar 5 1939</i>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>Shert. M. Gray Marshall, Mo</i>				
20. FILED <i>3-4-1939</i> <i>Mary Kent</i> Local Registrar.				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 3 1939*

22. I HEREBY CERTIFY, That I attended deceased from *March 3*, 1939, to *March 7*, 1939.

I last saw him alive on *March 7*, 1939. Death is said to have occurred on the date stated above, at *6:15 P.M.*

The principal cause of death and related causes of importance were as follows:

*Coronary embolism*

Date of onset

Other contributory causes of importance:

*Arterio-sclerosis Hypertension.*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *yes*

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? \_\_\_\_\_

If so, specify *John R. Lawrence*, M. D. (Signed) *Marshall, Mo.* (Address)

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed *H/10/39*

**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, \_\_\_\_\_

\_\_\_\_\_, or by \_\_\_\_\_

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

Signed *K.P.M. Cray*

Licensed Embalmer No. *31531*

P. O. Address \_\_\_\_\_

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

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