

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

33307
Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 735
 (b) Township Sugar Creek Primary Registration District No. 3034 Registered No. 167
 (c) City Moberly (d) Street No. McComick Hospital 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

THURMAN B. ESRY
 (a) Residence, No. RFD #1 JACKSONVILLE MO. (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 _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May-28-1926
7. AGE YEARS 13 MONTHS 3 DAYS 9 IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION **8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.** _____
9. Industry or business in which work was done, as saw mill, bank, etc. School boy
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) Randolph, Co. Missouri
FATHER **13. NAME** Lesslie Estry
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Moberly MO
MOTHER **15. MAIDEN NAME** Genevieve Brantegen
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rich Hill Missouri
17. INFORMANT (ADDRESS) Lesslie Estry RFD #1 Jacksonville Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Antioch Cemetery DATE Sept. - 7 - 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Snuff Funeral Home Moberly Mo.
20. FILED Sept 7 1939 Leah Williams Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 6, 1939
22. I HEREBY CERTIFY That I attended deceased from August 29, 1939, to September 6, 1939
 I last saw him alive on September 6, 1939 Death is said to have occurred on the date stated above, at 8:20 A.M.
 The principal cause of death and related causes of importance were as follows:
Streptococcal infection of face Date of onset 9-22-39
 Other contributory causes of importance: _____
 Name of operation forming infected abscess Date of 9-5-39
 What test confirmed diagnosis? Microscopic Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) A. L. McComick, M. D.
 (Address) Moberly

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

36
RECEIVED

District Health Officer No. 10

District File Number 10-39-1825

Date Filed OCT 11 1939

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 Myself
and R. M. Cates, Registered Apprentice No. 1837
working under my personal supervision.

Signed Chas. E. Barnes

Licensed Embalmer No. 2414

P. O. Address Moberly Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33307
Do not use this space.

1. PLACE OF DEATH
(a) County Randolph Registration District No. 735-
(b) Township Moberly Primary Registration District No. 3034 Registered No.
(c) City Moberly (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 Thurman B. Eary
(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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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.
13 3 9

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-6, 1939

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:
Streptococcus infection Date of onset
face 36
Other contributory causes of importance:
probably from picking a pimple.

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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
(Signed) J. L. McComick D.
(Address) Moberly Mo

SUPPLEMENTAL

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

