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FEB 14 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **2047**

Registration District No. **121** Primary Registration District No. **5173** Registrar's No. \_\_\_\_\_

15  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County **Camden**  
(b) City or town **Decaturville Rural**  
(c) Name of hospital or institution: **1 Warren Hwy**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community **life** years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Camden**  
(c) City or town **Decaturville Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Mary Malinda Thomas**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan** day **2** year **1941** hour **2** minute **30 A.**

4. Sex **female** 5. Color of race **white**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Jan 25 1858**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 2 1941** to **Jan 2 1941** that I last saw her alive on **Jan 2 1941** and that death occurred on the date and hour stated above.

8. AGE: Years **81** Months **11** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebral Hemorrhage 1941**  
Duration \_\_\_\_\_

9. Birthplace **near Decaturville, Camden Co. MO.**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to **(?)**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation **housewife**  
11. Industry or business \_\_\_\_\_  
12. Name **Thomas Richard Parish**  
13. Birthplace **St. Louis**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Reese**  
15. Birthplace **Penn.**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings: Of operations **no operation**  
Of autopsy **no**

16. (a) Informant **Geo. + Hobert Thomas**  
(b) Address **Decaturville Mo**  
17. (a) **Burial** (b) Date thereof **Jan 4 - 1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Union Cemetery**  
18. (a) Signature of funeral director **Bankson - Wooley**  
(b) Address **Camden Mo**  
19. (a) **Jan 9, 1941** (b) **Mr. Wella Carborn**  
(Data received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **Ed Cleburne M.D.**  
Address **Camden Mo** Date signed **Jan 8 41**

RECEIVED

District Health Officer No. 7.

District File Number 2-41-252

Date Filed 2-7-41

DATE

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 A. H. Bankson Wooler

Licensed Embalmer No. 2488

P. O. Address Camden, Md.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2047

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 121

Primary Registration District No. 2173

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cassden  
(b) City or town Warren Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Mary Matilda Thomas

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced wd

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 25 - 1858  
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan 1946 (b) Miss Wella Clark  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month Jan day 2  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ n. (e) Means of injury \_\_\_\_\_

23. Signature E. E. Claiborne (M. D. or other)

Address Conducta, Mo Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

