

0. 2
13-40
7-39
X23159

FILED APR 3 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11192

State File No.

Registration District No. 1041470

Primary Registration District No. 5633

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 177 days
(Specify whether

In this community 177 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

(c) City or town Fayette
(If outside city or town limits, write "RURAL")

(d) Street No. 706 North Church St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mary Thomason

3. (b) If veteran, name was No

3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1941 hour 8:00 minute p M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Herman Thomason

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown Apr. 20th 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 19th, 1940 to March 10th, 1941; that I last saw her alive on March 10th, 1941; and that death occurred on the date and hour stated above. About 2 yrs. Immediate cause of death _____

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>10</u>	<u>19</u>	hr. _____ min. _____

Due to Pneumonia

Due to _____

Other conditions (Include pregnancy within 3 months of death) 172 B1

9. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name James H. Allen

13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Nora Chandler

15. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

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? 421
(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature Charles J. ... (M.D. or other) _____
Address ... Date signed ...

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removed (b) Date thereof 3-12-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

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

(b) Address Springfield, Mo.

19. (a) 3-16-1941 (b) B.A. Holme S
(Date received local registrar) (Registrar's signature)

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

5000

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.....

Licensed Embalmer No.....

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, fact should be so stated above.