

FILED AUG 19 1948  
Registration District No. **103248**

Primary Registration District No. **3026**

59  
1  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County. Lincoln  
 (b) City or town. Chillicothe  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 2 1/2 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME J. P. Throuburgh  
 3. (b) If veteran.  name war. ✓  
 3. (c) Social Security No. ✓

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced, widower 2 divorced widower  
 6. (b) Name of husband or wife. —  
 6. (c) Age of husband or wife if alive. — years  
 7. Birth date of deceased. May 10 1847  
 (Month) (Day) (Year)

8. AGE: Years 95 Months 2 Days 2  
 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER  
 12. Name Calvin Throuburgh  
 13. Birthplace Unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Ethel A. Brummett  
 (b) Address Princeton Mo.

17. (a) Removal (b) Date thereof 2-14-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation. Farley

18. (a) Signature of funeral director. Paul Moss  
 (b) Address Princeton Mo.

19. (a) July 13 - 1948 (b) Low E. Hall  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State. Mo. (b) County. 59  
 (c) City or town. 1  
 (If outside city or town limits, write "RURAL") 2  
 (d) Street No. — (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country —

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July Day 12  
 year 1942 hour 8 minute 30 M. A

21. I hereby certify that I attended the deceased from 7 years  
 to —, 19 — to —, 19 —  
 that I last saw him alive on 6-28-42  
 and that death occurred on the date and hour stated above.

Immediate cause of death. Neurovascular Duration —  
Brain  
 Due to Artero-sclerosis  
 Due to —

Other conditions —  
 (Include pregnancy within 3 months of death) 8 20'

Major findings:  
 Of operations —  
 Of autopsy —

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

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) None  
 (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)  
 (a) Means of injury Truck  
 23. Signature Richard G. Gentry (M. D. or other) 194  
 Address Chillicothe Mo. Date signed 7-13-48

**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.....

*James D Gordon*

Licensed Embalmer No. *1870*

P. O. Address *Lehillicothe 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24735

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Chillicothe  
(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 2 1/2 yrs.  
years, months or days

3. (a) PRINT FULL NAME

S. P. Thornburgh

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased May 10  
(Month) (Day) (Year)

8. AGE: Years 95 Months 2 Days 14 If less than one day \_\_\_\_\_ min.

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

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

11. Industry of business \_\_\_\_\_

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) July 13-1942 (b) Lo Ella Curry  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day \_\_\_\_\_  
Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

