

FILED DEC 17 1943

Registration District No. 64

Primary Registration District No. 4.110

Registrar's No. 54

21  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Pharos

(b) City or town Salisbury  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pharos

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LUTHER-BROWN-THRASH

3. (b) If veteran, name war ✓

3. (c) Social Security No. 487-12-1324

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7 year 1943 hour 4 minute 40 P. M.

4. Sex MALE 5. Color or race white

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

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

6. (e) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased sex 6 1971  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 31 1943 to November 7 1943; that I last saw him alive on Nov 7 1943 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

72 2 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage

Due to hypertension and generalized arteriosclerosis

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

9. Birthplace St. Louis MO  
(City, town, or county) (State or foreign country)

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

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

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

10. Usual occupation Meat Cutter (Butcher)

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

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? \_\_\_\_\_

12. Name William Thrash

13. Birthplace St. Louis MO  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

8301

14. Maiden name Julia Cannon

15. Birthplace St. Louis MO  
(City, town, or county) (State or foreign country)

16. (a) Informant William Thrash

(b) Address Pharos

17. (a) Pharos (b) Date thereof Nov 9 - 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keytesville

18. (a) Signature of funeral director W. L. Smith

(b) Address Keytesville

19. (a) 11-10 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature J. L. Adams (M. D. or other) MD

Address Salisbury MO Date signed 11-9-43

1025

RECEIVED

Officer No. 8,

12-14-43

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**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 N. D. Garnett.....

Licensed Embalmer No. 3046.....

P. O. Address Key West, 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.**