

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 11 1945  
340

Registration District No. \_\_\_\_\_ Primary Registration District No. 4503

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Bernie  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
North part of town  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 20 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Bernie  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME

George R. Thurston

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex Male

5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Maddie Thurston

6. (c) Age of husband or wife if alive or deceased years 60

7. Birth date of deceased August 19 1863  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Painter

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

12. Name Joseph Thurston

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

14. Maiden name Unknown

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

16. (a) Informant Earl Thurston

(b) Address Bernie, Mo.

17. (a) Burial (b) Date thereof 12/13/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bryndon Co. Missouri

18. (a) Signature of funeral director Clayton E. Smith

(b) Address Bernie, Mo.

19. (a) 12-30-45 (b) Cardie Miller  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12  
year 1945 hour 8:30 minute 0 A.M.

21. I hereby certify that I attended the deceased from 12-12-1945 to 12-12-1945 that I last saw him alive on 12-12-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Serility

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

Other conditions (Include pregnancy within 3 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) (e) Means of injury \_\_\_\_\_

23. Signature Dawsey Ryan (M. D. or other) \_\_\_\_\_  
Address Bernie Mo Date signed 12-19-45

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 146-5

Date Filed 1-7-46

**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: J. Is. Schuman

Licensed Embalmer No. 4086

P. O. Address: Malden

**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.**