

FILED OCT 11 1946

State File No. _____

Registration District No. 96

Primary Registration District No. 5350

Registrar's No. 623

1. PLACE OF DEATH

(a) County Dallas
 (b) City or town Rural - Lincoln
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30
 (c) City or town Rural 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Elmer Mackland E. Thridge

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 Widowed

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

7. Birth date of deceased Aug 24 1879
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 19 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Elizabeth W. E. Thridge

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

14. Maiden name Elizabeth Southard

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

16. (a) Informant Mr. Carl E. Thridge

(b) Address Urbana, Mo.

17. (a) Bk. 101 (b) Date thereof Sept. 15, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mission Ridge Cem.

18. (a) Signature of funeral director Wayman Ryan

(b) Address Urbana, Mo.

19. (a) 9-30-46 (b) Thorge Petrus
 (Date received local register) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13
 year 1946 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 1 to Sept 13 1946
 that I last saw him alive on Sept 13 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death: Stroke
Stroke
 Duration 6 mo

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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) _____

(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 L. A. Blois (M. D. or other) M.D.

Address Urbana Mo. Date signed Sept 14, 1946

RECEIVED
D: _____
Date: _____
Licor No. 7,
9-46-1031
10-9-46

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 Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urban, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 96 Primary Registration District No. 6850

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Paris
(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 Elmer M. Ethridge
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 Wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 24
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or 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) 9-30-46 (b) Grace Petric
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I saw him _____ 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)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____

SUPPLEMENTARY

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

MOTHER FATHER

29906