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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 33811
Registrar's No. 4309

FILED SEP 2 1946

Registration District No. _____ Primary Registration District No. 1002

**1. PLACE OF DEATH:**
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 309 Garfield, Conv. Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 month (Specify whether years, months or days)
In this community: 2 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 1217 Baltimore (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Mrs. Fay ~~Squires~~ THURMAN
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: McCellen L. Thurman
6. (c) Age of husband or wife if alive: 49 years
7. Birth date of deceased: February (Month) 19 (Day) 1887 (Year)

8. AGE: Years 59 | Months 7 | Days 22 | If less than one day: hr. min.

9. Birthplace: Highland (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: At home
12. FATHER Name: Thomas Squires
13. FATHER Birthplace: -- (City, town, or county) Unknown (State or foreign country)
14. MOTHER Maiden name: Georgiana White
15. MOTHER Birthplace: -- (City, town, or county) Unknown (State or foreign country)
16. (a) Informant: Mr. McCellen L. Thurman
(b) Address: 1217 Baltimore, K. C., Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 10-12-46 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Joseph, Mo.
18. (a) Signature of funeral director: Mellody-McGilley-Eylar
(b) Address: Kansas City, Missouri
19. (a) 10-12-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 11 year 1946 hour 5 minute 15 P.M.
21. I hereby certify that I attended the deceased from Nov. 16, 1945 to Oct. 11, 1946 and that I last saw he alive on Sept. 1, 1946 and that death occurred on the date and hour stated above.
Immediate cause of death: General Cardiovascular Syph
Due to: _____
Due to: _____
Other conditions (Include pregnancy within 3 months of death): _____
Major findings: Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? (Specify type of place): _____
While at work? _____ (e) Means of injury: _____

23. Signature: V. W. Furrow (M. D. or other) D.O.
Address: 402 Westbrooke Bldg. Date signed: 10-12-46

(Licensed Embalmer's Statement on Reverse Side)

## 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 Glen E. Heck

Licensed Embalmer No. 4063

P. O. Address Kansas City, 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.**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED OCT 28 1946

State File No. ____

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4309

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 309 Garfield conv. Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

**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 ____

3. (a) PRINT FULL NAME Fay Thurman

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

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

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

7. Birth date of deceased ____ (Month) (Day) (Year)

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

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

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

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) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) 10-12-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 11 year 1946 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death ____ Duration

General carcinomatosis 4 yrs.

Due to primary site - Breast

Due to ____

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

Major findings:
Of operations ____
Of autopsy ____

60

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature V. W. Harned (M. D. or other)

Address 402 Winthrop Bldg. Signed 10-12-46

SUPPLEMENTARY

N. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very importa

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# STANDARD CERTIFICATE OF DEATH

*State File No.*.....

Registration District No.....  Primary Registration District No.....  *Registrar's No.*.....

**1. PLACE OF DEATH:**

(*a*) County.....

(*b*) City or town.....
(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..... (*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.....

3. (*a*) **PRINT FULL NAME**.....

3. (*b*) If veteran, name war..... 3. (*c*) Social Security No.....

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

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

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

8. **AGE:** Years | Months | Days | If less than one day .....hr. .....min.

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

10. Usual occupation.....

11. Industry or business.....

FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) ..... (State or foreign country)

MOTHER { 14. Maiden name.....
15. Birthplace..... (City, town, or county) ..... (State or foreign country)

16. (*a*) Informant.....
(*b*) Address.....

17. (*a*) ..... (Burial, cremation, or removal) (*b*) Date thereof..... (Month) (Day) (Year)
(*c*) Place: burial or cremation.....

18. (*a*) Signature of funeral director.....
(*b*) Address.....

19. (*a*) ..... (Date received local registrar) (*b*) ..... (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month.....day.....
year.....hour.....minute.....M.

21. I hereby certify that I attended the deceased from.....
.....,19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

| | *Duration* |
|---|---|
| Immediate cause of death..... | |
| Due to..... | |
| Due to..... | |
| Other conditions..... (Include pregnancy within 3 months of death) | |

33811

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?
..... (Specify type of place)
While at work?..... (*e*) Means of injury.....

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.