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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 13 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7693

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 6275

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Near Allendale Mo.  
(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 years, months or days)

In this community 20 years

3. (a) PRINT FULL NAME Clara Thurman

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

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

6. (b) Name of husband or wife Buelah Thurman 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased July 18- 1870  
(Month) (Day) (Year)

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

76 6 18 hr. min.

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

10. Usual occupation Farmer

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

12. Name George Thurman

13. Birthplace Not known (City, town, or county) (State or foreign country)

14. Maiden name Mary Anderson

15. Birthplace Not known (City, town or county) (State or foreign country)

16. (a) Informant Buelah Thurman

(b) Address Hatfield, Mo.

17. (a) Burial (b) Date thereof Feb 8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ringgold, Iowa

18. (a) Signature of funeral director C. D. Spodner

(b) Address Mont Air, Iowa

19. (a) 2-8-47 (b) Leta E. Dawson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth

(c) City or town Rural Near Allendale  
(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 February day 6  
year 1947 hour 9:30 a.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb 1st 1947 to Feb 6th 1947, that I last saw him alive on Feb 6th 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

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

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

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

Major findings: Of operations 83\*

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 O. R. Fullerton (M. D. or other) \_\_\_\_\_  
Address Redding, Ia. Date signed 2/6-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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345

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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 *C. O. Rhoads*.....

Licensed Embalmer No. 2479.....

P. O. Address Mt Airy Ga......

**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.