

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

**1. PLACE OF DEATH:**

(a) County Cooper

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

(c) Name of hospital or institution: Van Rensselaer Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

**2. (a) PRINT FULL NAME** NORMA G. THEROFF

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

**4. Sex** Female **5. Color or race** white

**6. (a) Single, widowed, married,** divorced (1)

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

**7. Birth date of deceased** OCT 16 1946  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
	<u>5</u>	<u>15</u>	hr. _____ min. _____

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

**10. Usual occupation** \_\_\_\_\_

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

**MOTHER**

**FATHER**

**12. Name** Walter Theroff

**13. Birthplace** Polk Co. Mo.  
(City, town, or county) (State or foreign country)

**14. Maiden name** Amya Lehman

**15. Birthplace** Centerville Mo.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Walter Theroff

**(b) Address** Russellville MO

**17. (a) Burial** (b) Date thereof 4-2-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** ENLOE

**18. (a) Signature of funeral director** [Signature]

**(b) Address** Russellville MO

**19. (a) 4-2-47** (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Coll. 26

(c) City or town Russellville  
(If outside city or town limits, write "RURAL") 1

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

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month April day 31  
year 1947 hour 15 minute 0 M.

**21. I hereby certify that I attended the deceased from** February 13  
1947 to March 30 1947  
and that death occurred on the date and hour stated above.

**Immediate cause of death** to whooping cough  
pneumonia 6 weeks

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

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

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

**PHYSICIAN**

**Major findings:** None

**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** [Signature] (M. D. or other)

**Address** Russellville Mo **Date signed** 4.31.47

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 4-11-47

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**

*Not-embalmed*