

FILED OCT 17 1947

Registration District No. **264**

Primary Registration District No. **5891**

Registrar's No. **23**

1. PLACE OF DEATH:
 (a) County **Ozark**
 (b) City or town **Rural - Bridges**
 (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 **5 months**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Narvel Thorsland**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **464-22-7953**

4. Sex **male** **0** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Ethel Thorsland**
 6. (c) Age of husband or wife if alive **28** years
 7. Birth date of deceased **August 30 1909**
 (Month) (Day) (Year)

8. AGE: Years **38** Months **0** Days **8**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Jack Thorsland, Jr.**

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

14. Maiden name **Etter Mitchell**

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

16. (a) Informant **Parent, Huddleston**

(b) Address **1107 So. 13th St. Louisville, Mo.**

17. (a) **B** (b) Date thereof **9-10-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Center Point Cem.**

18. (a) Signature of funeral director **Clintford Funeral Home**
Gainesville, Mo.

(b) Address _____
 19. (a) **Sept. 10, 1947** (b) **Paula Trump**
 (Day received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Ozark** **77**
 (c) City or town **Gainesville - rural** **0**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) **0**
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **September** day **8**
 year **1947** hour **1** minute **30** A. M.

21. I hereby certify that I attended the deceased from **August 29**, 19**47**, to **Sept 5**, 19**47**, and that I last saw him alive on **Sept 4**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis with hemorrhage**
 Due to **Chronic Pulmonary TB**
 Duration **2 wk**
 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 **2**
 23. Signature **M. J. Sterman** (M. D. or other) **DD**
 Address **Gainesville, Mo.** Date signed **9/10/47**

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

17
00

RECEIVED

District Health Officer No. 6;

District File Number 1047-1049

Date Filed OCT 19 1947

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..... W.B. Hutchison.....

Licensed Embalmer No. 3431.....

P. O. Address Gaunsville Mo.....

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

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