

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **23944**

FILED AUG 2 1949

BIRTH NO. _____ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **3083** Registrar's No. **117**

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give town) Lebanon		c. CITY (If outside corporate limits, write RURAL and give township) Lebanon	
c. LENGTH OF STAY (In this place) Unknown		d. STREET ADDRESS (If rural, give location) 404 Pearl St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wallace Memorial			
3. NAME OF DECEASED a. (First) Thomas H. b. (Middle) Jurner c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) July 22 1949
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 17 1867
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Section foreman	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Laclede Co. Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME G. P. Jurner		13b. MOTHER'S MAIDEN NAME Louisa Knox	
14. NAME OF HUSBAND OR WIFE Cassie Jurner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Socia Lee		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc.: It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Chronic nephritis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Prostatic Hypertrophy Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 5-10 , 19 49 , to 7-22 , 19 49 , that I last saw the deceased alive on 7-22 , 19 49 , and that death occurred at 2:30 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE T. Jurner M.D. (Degree or title)		23b. ADDRESS Lebanon Mo	
23c. DATE SIGNED 7-25-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/25/49	
24c. NAME OF CEMETERY OR CREMATORY Stoutland Cemetery		24d. LOCATION (City, town, or county) (State) Stoutland Mo.	
DATE REC'D BY LOCAL REG. July 25-1949		REGISTRAR'S SIGNATURE W. E. Holman ADDRESS Lebanon, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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Received JUL 30 1949

Laclede County Health Unit

File No. 7-49-101

Date Filed AUG 1 1949

SEP 27 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.