

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41053

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5124

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>25 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>2430 Woodland</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2430 Woodland</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Laura</b> b. (Middle) <b>Thurman</b> c. (Last) <b>Thurman</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 1 50</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 1-1885</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Decatur Ga.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					

13a. FATHER'S NAME <b>James Jackson</b>		13b. MOTHER'S MAIDEN NAME <b>Delia ?</b>		14. NAME OF HUSBAND OR WIFE <b>Wyatt J. Thurman</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Wyatt J. Thurman 2430 Woodland</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Apoplexy</b>		ANTECEDENT CAUSES <b>Hypertension</b>			<b>Nov. 30</b>	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>—</b>			<b>Sept. 1950</b>	
		DUE TO (c) <b>—</b>			<b>307 1/2</b>	
II. OTHER SIGNIFICANT CONDITIONS <b>—</b>		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"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Nov. 17, 1950** to **Dec. 1, 1950**, that I last saw the deceased alive on **Nov. 30, 1950**, and that death occurred at **3:15 p.m.** on the causes and on the date stated above.

23a. SIGNATURE <b>D.-M. Miller</b> (Degree or title)		23b. ADDRESS <b>M.D. 1816 Vine St. Kc. Mo</b>		23c. DATE SIGNED <b>12-4-50</b>	
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24a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-6-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Westlawn Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>Kansas City Kansas</b>	

DATE REC'D BY LOCAL REG. <b>12-4-50</b>		REGISTRAR'S SIGNATURE <b>Seraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Nathan W. Thatcher Kansas City Ks</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

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, fact should be so stated above.