

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43722**

FILED JAN 12 1954

0720

BIRTH NO. _____		REG. DIST. NO. 240		PRIMARY REG. DIST. NO. 5827		Registrar's No. 3		
1. PLACE OF DEATH a. COUNTY New Madrid				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Caruthers Farm b. COUNTY New Madrid				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Newear Lilbourn, MO		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rual		0720		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital				d. STREET ADDRESS (If rural, give location) 0				
3. NAME OF DECEASED (Type or Print) Lenda Kay Thomas			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12 / 31 53		
5. SEX F.		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child		8. DATE OF BIRTH II, 16, 1953		
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months 1		IF UNDER 1 YEAR Days 15		IF UNDER 1 MIN. Hours 7 Mins. Am		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Non		11. BIRTHPLACE (City and State or Foreign Country) MO		12. CITIZEN OF WHAT COUNTRY? U.S	
13a. FATHER'S NAME Willie R. Thomas			13b. MOTHER'S MAIDEN NAME Lena May Webster			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME Willie R. Thomas 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) Pneumonia and ANTECEDENT CAUSES Intestinal Flu Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intestinal Flu DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 480x					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 12-29, 1953 , to 12-29, 1953 that I last saw the deceased alive on 12-29, 1953 and that death occurred at 4 Pm. , from the causes and on the date stated above.								
23a. SIGNATURE W. Bluff H. Chastain (Degree or title)				23b. ADDRESS Lilbourn, MO		23c. DATE SIGNED 12-29-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/31 53		24c. NAME OF CEMETERY OR CREMATORY Catron Cemetary		24d. LOCATION (City, town, or county) (State) Catron, MO		
DATE REC'D BY LOCAL REG. 1-4-54		REGISTRAR'S SIGNATURE A. J. Sonder Deputy		25. FUNERAL DIRECTOR'S SIGNATURE L. W. Hill		ADDRESS Lilbourn MO		

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

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. *Not Embalmed*

Student
Student Embalmer

Signed *J. W. Hill*

Licensed Embalmer No. *2687*

P. O. Address *Elbow 4th*

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.