

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20833**

FILED JUN 23 1955

No. 300
10.48

1030

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

BIRTH NO. _____		REG. DIST. NO. <u>391</u>		PRIMARY REG. DIST. NO. <u>4505</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bell City,</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bell City</u>		<u>1030</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bell City</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Donal</u> b. (Middle) <u>Roy</u> c. (Last) <u>Thrower,</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 17, 1955</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Never Married</u>		8. DATE OF BIRTH <u>8-16-1923</u>	
9. AGE (in years last birthday) <u>31</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>		IF UNDER 1 MIA. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Macanick</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Macanick</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Bell City Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>M.R. Thrower,</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Clark,</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1/18/49 to 8/11/49-496-20-5310</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Ann Thrower, Bell City, Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Possible skull fracture, deep laceration on left side of body beneath left arm pit, internal injuries.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>802X</u> Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>35</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE <u>accident</u> HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, hotel, etc.) <u>railroad tracks</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) / (STATE) <u>Bell City, Stoddard, Mo.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 17, 1955</u> <u>Unknown</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Believed to have been struck by train.</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>unknown</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Way W. Spring</u> (Degree or title) <u>Coroner</u>				23b. ADDRESS <u>Dexter, Missouri</u>		23c. DATE SIGNED <u>5-18-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/19/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plesant Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Stoddard County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Bernice Moore</u>		360- FUNERAL DIRECTOR'S SIGNATURE <u>Coy Shelly, Bell City, Mo.</u>		ADDRESS	

10-28-910

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 *Charles E. Mung*

Licensed Embalmer No. *4877*

P. O. Address *Cape Girardeau*

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.