

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 30 1956

BIRTH NO. _____ REG. DIST. NO. 238 PRIMARY REG. DIST. NO. 4355 Registrar's No. 3

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>New Madrid</u> | | c. LENGTH OF STAY (in this place) | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | e. STREET ADDRESS (If rural, give location) | |

| | | | | | |
|--|------------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Lucy</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Thomas</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 12 1956</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Nov. 15 1881</u> | 9. AGE (In years last birthday) <u>74</u> | 10. IF UNDER 1 YEAR Days <u>1</u> Hours <u>27</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Clarksdale, Mississippi</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

| | | | | | |
|---|--|--|--|--|--|
| 13a. FATHER'S NAME <u>Frank Strons</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mag Hopson</u> | | 14. NAME OF HUSBAND OR WIFE <u>1</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Shawk Thomas - New Madrid, 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>No. Medical attendants</u> | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>by all record, death was due to</u> DUE TO (c) <u>the labor Pneumonia</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>490x</u> | | | |

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 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) (Min.) | | 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:30 a. m., from the causes and on the date stated above.

| | | | | | |
|---|--|---|--|--|--|
| 23a. SIGNATURE <u>L. H. Helgeseth</u> (Degree or title) <u>Coroner</u> | | 23b. ADDRESS <u>New Madrid, Mo.</u> | | 23c. DATE SIGNED <u>1/16-56</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>1-18-56</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Sand Hill</u> | |
| | | 24d. LOCATION (City, town, or county) (State) <u>New Madrid, Mo.</u> | | | |

| | | | | | |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <u>1/16/56</u> | | REGISTRAR'S SIGNATURE <u>Tommy L. Roberts</u> <u>218</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ponder Funeral Home - Lilbourn, Mo.</u> | |
|--|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 31 1956

DATE RECEIVED JAN 25 1955
NEW MADRID CO. HEALTH CENTER
P. J. S.

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,
Signature of Student Embalmer

Signed Homer L. Ponder

Licensed Embalmer No. 336

P. O. Address Tilbourn

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.