

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36724**

FILED NOV 9 - 1956

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **167**

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

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) 5 Days	c. CITY OR TOWN Bell City
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital		STREET ADDRESS (If rural, give location) 10301	

3. NAME OF DECEASED a. (First) Anna b. (Middle) Lou c. (Last) Thrower		4. DATE OF DEATH (Month) (Day) (Year) 10 13 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-29-1888
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 00 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 0	11. BIRTHPLACE (City and State or Foreign Country) Garmi, Illinois
13a. FATHER'S NAME James Clark		13b. MOTHER'S MAIDEN NAME Anna Cotton,	14. NAME OF HUSBAND OR WIFE Marion Randolph Thrower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Marion Thrower, Bell City, Mo.
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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 1 wk.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Gen. arteriosclerosis		
		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332.X	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)	21e. INJURY OCCURRED *WHILE AT WORK <input type="checkbox"/> 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 **10-10**, 19**56**, to **10-13**, 19**56**, that I last saw the deceased alive on **10-12**, 19**56**, and that death occurred at **6:35A.m.**, from the causes and on the date stated above.

23a. SIGNATURE E.D. Urban M.D.	(Degree or title) M.D.	23b. ADDRESS Sikeston	23c. DATE SIGNED 10-18-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-15-56	24c. NAME OF CEMETERY OR CREMATORY pleasant Home Cemetery	24d. LOCATION (City, town, or county) (State) Bell City, Stoddard Mo.
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DATE REC'D BY LOCAL REG. 11-2-56	REGISTRAR'S SIGNATURE Mrs. Ella Hunter	25. FUNERAL DIRECTOR'S SIGNATURE Coyle Shethley	ADDRESS Bell City, Mo.
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DATE RECEIVED NOV 5 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1156-232

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

Raymond L. Duffie

Licensed Embalmer No. 479

P. O. Address Berme, 7

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.