

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022683

STATE FILE NUMBER

49194-57  
FILED JUN 18 1958

Registration District No. 2.39 Primary Registration District No. 5825 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <b>New Madrid</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Catron</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Catron</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Tertha Thomas</b>				First <b>Tertha</b> Middle <b>Thomas</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 22 1957</b>		9. AGE (In years last birthday) If UNDER 1 YEAR: Months <b>11</b> Days _____ Hours _____ Min. _____ If UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Catron Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Dallas Gully</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Thomas</b>			
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 <b>Lillie Thomas</b> Address <b>Catron Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Died unattended - probably whooping cough</b>						INTERVAL BETWEEN ONSET AND DEATH <b>0560</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Catron Mo.</b>		20g. COUNTY STATE	
21. I attended the deceased from <b>died unattended</b> to _____ and last saw her/him alive on _____ Death occurred at <b>4:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>E. E. Jones M.D.</b> (Degree or title)				22b. ADDRESS <b>Lilbourn</b>		22c. DATE SIGNED <b>Mo</b>	
23a. BURIAL, CREMATION, REBURY, ETC. (Specify)		23b. DATE <b>May 24, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>colored Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Catron Mo.</b>		
24. FUNERAL DIRECTOR <b>Watson Fun. Service</b> ADDRESS <b>Parma Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>5/29/58</b>		26. REGISTRAR'S SIGNATURE <b>Dr. Leo W. Hunter, M.D.</b>		

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED JUN 5 1958  
NEW MADRID CO. HEALTH CENTER

P. J. L.

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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.....  
Signature of Student Embalmer

Signed..... Mark Withers

Licensed Embalmer No. 471

P. O. Address Perkins

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.