

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010368
STATE FILE NUMBER

FILED APR 15 1959

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 30

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

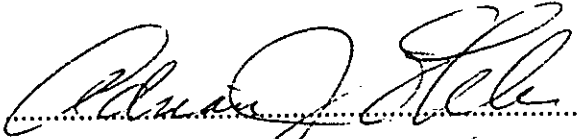
1. PLACE OF DEATH a. COUNTY <u>PERRY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. MARY'S</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PERRYVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. MARY'S</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PERRY CO. MEMORIAL</u>		Length of stay in 1b <u>15 MIN</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TOBIE</u> Middle <u>JOSEPH</u> Last <u>THOMURE</u>				4. DATE OF DEATH Month <u>MAR</u> , Day <u>21</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 15 1888</u>		9. AGE (In years last birthday) <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK CASHIER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>RIVER AUX VASES MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>TOBASIS THOMURE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN RIGDON</u>		14. NAME OF HUSBAND OR WIFE <u>LEONORE CALDWELL</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>488-01-6186</u>		17. INFORMANT <u>Eugene Thomure Sr. Quincy, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema and Right Sided Heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>-5-10 yrs</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4200</u>					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>6158</u>		20f. CITY, TOWN, OR LOCATION <u>ST. MARY'S</u>		COUNTY <u>ST. MARY'S</u> STATE <u>MO</u>	
21. I attended the deceased from <u>6/58</u> to <u>3/21/59</u> and last saw her alive on <u>3/21/59</u> . Death occurred at <u>509 4th</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Eugene F. Luthardt MD</u>				22b. ADDRESS <u>ST. MARY'S</u>		22c. DATE SIGNED <u>3/21/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/24/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		23d. LOCATION (City, town, or country) (State) <u>ST. MARY'S MO</u>	
24. FUNERAL DIRECTOR <u>Res. C. Barker & Co. St. Louis, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>3-25-59</u>		26. REGISTRAR'S SIGNATURE <u>Joseph J. Zoller</u>	

APR 15 1959

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 

Licensed Embalmer No. 4740

P. O. Address 

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.