

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS NOV 10 1959

59-035645

STATE FILE NUMBER

Registration District No. 86 Primary Registration District No. 5377 Registrar's No. \_\_\_\_\_

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Crawford</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>                 |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Benton Twp.</u>  |  | Length of stay in 1b<br><u>10 years</u>   |  | c. CITY OR TOWN <u>Leasburg</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>At Home</u>  |  |   |  | d. STREET ADDRESS (If outside, give location)<br><u>1 mi North of City Limits</u>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Thomas Franklin ENNIS</u>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>Nov. 5 1959</u>  |  |  |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Nov. 24 1888</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 9. AGE (last birthday)<br><u>71</u>   |  | IF UNDER 1 YEAR<br>Months Days   |  |
| 11. BIRTHPLACE (City and state or country)<br><u>Sullivan, Mo.</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |  |  |
| 13a. FATHER'S NAME<br><u>Edward ENNIS</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Malinda STROUP</u> |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>MINTIE RAY</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No Nil</u>  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Mrs MINTIE ENNIS</u>  |  | Address<br><u>Leasburg Mo.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u>   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3-Day</u>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>PARALYSIS AGITANS</u>  |  |   |  |   |  | <u>18 Yr</u>   |  |
| DUE TO (c) <u>General Arterio Sclerosis</u>  |  |   |  |   |  | <u>10 y#</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 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.)  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.  |  |   |  |   |  |  |  |
| 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  |  | COUNTY STATE   |  |
| 21. I attended the deceased from <u>15 Sept 1952</u> to <u>5 Nov 1959</u> and last saw him alive on <u>5 Nov 1959</u><br>Death occurred at <u>Home-5 Nov-59 2:45 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Joseph T De Leo, M.D., D.C., M.H.</u>   |  |   |  | 22b. ADDRESS<br><u>BOX 255 CUBA MO</u>  |  | 22c. DATE SIGNED<br><u>6-2-59</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>Nov. 7-1959</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Crossroads</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Leasburg Mo.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Norman R Hooper</u>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>11-6-1959</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 18 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 Norman C. Ho  
Licensed Embalmer No. 4673

P. O. Address Quila,

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.