JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-007856

STATE FILE NUMBER

FILED VS FEB 24 1960

NDED

Registration District No. 316 Primary Registration District No. — Registrar's No. 61

DOCUMENT

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RR 1 Bonne Terre,
Length of stay in 1b: 15 yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Residence
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri, b. COUNTY St. Francois
c. CITY OR TOWN Bonne Terre, RR 1
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) RR # 1
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Margie Middle: Alice Last: Thurman

4. DATE OF DEATH Month: February Day: 12 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 9/8/1880

9. AGE (last birthday): 79yrs.

IF UNDER 1 YEAR: Months 5, Days 4

IF UNDER 24 HR: Hours 23, Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Iron County Missouri U.S.A.

12. CITIZEN OF WHAT COUNTRY:

13a. FATHER'S NAME: James Chapman

13b. MOTHER'S MAIDEN NAME: Alberta Thompson

14. NAME OF HUSBAND OR WIFE: William Aaron Thurman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William A. Thurman, Address: Bonne Terre, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unk.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Malnutrition

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 November 1959 to February 12 1960 and last saw him alive on Jan 29, 1960

Death occurred at 11:10 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jack Muller MD (Degree or title)

22b. ADDRESS Bonne Terre, Mo.

22c. DATE SIGNED 2/13/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2/15/60

23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery,

23d. LOCATION (City, town, or county) (State) Bismarck, Missouri

24. FUNERAL DIRECTOR SBARKS FUNERAL HOME ADDRESS BONNE TERRE, MO.

25. DATE RECD. BY LOCAL REG. Feb. 15 1960

26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4236

P. O. Address _____

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