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X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 5 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8318  
State File No. \_\_\_\_\_  
Registrar's No. 20

Registration District No. 99 Primary Registration District No. 4168

1. PLACE OF DEATH:  
(a) County De Kalb  
(b) City or town Maysville Mo  
(c) Name of hospital or institution: Home  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Life \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo, (b) County De Kalb  
(c) City or town Clarksdale Mo  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME Elizabeth Francis Thorpe  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 12 1851

8. AGE: Years 96 Months 3 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Lexington Mo Housewife

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Presley Gordon  
13. Birthplace Kent, 4  
14. Maiden name Rebecca Brooks  
15. Birthplace Kent 4

16. (a) Informant Bill Gordon (b) Address Clarksdale Mo.

17. (a) Burial (b) Date thereof 3 10-48 (c) Place: burial or cremation Clarksdale Mo

18. (a) Signature of funeral director John B. Brown (b) Address Maysville Mo

19. (a) 3-20-48 (b) Registrar's signature \_\_\_\_\_ (c) Date received local registrar \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 14 year 1948 hour 3 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from 2-1-47 to 3-14-48; that I last saw her alive on 3-9-48; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema 9 hrs.  
Due to Senility  
Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature Dr. OR Van Dine (M. D. or other) \_\_\_\_\_  
Address 823 FARAON, N. W. Ph. \_\_\_\_\_ Date signed 3-25-48

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *John P. Brown*  
Licensed Embalmer No. *319 33*  
P. O. Address *Mayfield, Mo.*

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 this body is not embalmed, fact should be so stated above.