

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

27907  
3599

**1. PLACE OF DEATH**

County Jackson Registration District No. 309  
Township Kays Primary Registration District No. 1002  
City St. Louis (No. 3100 Euclid Ave)

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Madeline Thurman  
(a) Residence. No. 3223 Campbell St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>E. N. Thurman</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 30<sup>th</sup> 1876</u>		
7. AGE YEARS <u>53</u>	MONTHS <u>3</u>	DAYS <u>23</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at Home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/24/29 1929

17. I HEREBY CERTIFY, That I attended deceased from July 21<sup>st</sup>, 1929, to August 22<sup>nd</sup>, 1929 that I last saw her alive on Aug 24<sup>th</sup>, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
apoplexy (cerebral hemorrhage)  
9 hrs. (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) manic depressive psychosis  
(duration) \_\_\_\_\_ yrs. 5 mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH Don't Know  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS clinical  
(Signed) Herma S. Mason, M. D.  
Aug 23, 1929 (Address) 3100 Euclid Ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) Troy Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Francis M. Harlan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Oldfield

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY)

14. INFORMANT E. N. Thurman  
(Address) 3223 Campbell

15. FILED 8/23, 1929 M. M. Crowe  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Troy Mo DATE OF BURIAL 8/24/29 1929

20. UNDERTAKER H. F. Mayberry ADDRESS City, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

235  
1  
2

