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.

I X12004

REC'D MAR 20 1939

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

6735
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 2 Registration District No. 398
(b) Township 1 Primary Registration District No. 3019 Registered No. 62
(c) City Independence (d) Street No. 816 N. Dodgion St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 7 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 655 Matilda Ellen Thurman
(a) Residence, No. 816 N. Dodgion St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Henry J. Thurman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 26, 1856

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
82	5	22	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark County Iowa 1

FATHER
13. NAME Anderson Lyons
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record Iowa 1

MOTHER
15. MAIDEN NAME Sarah Frank 1
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record Iowa.

17. INFORMANT (ADDRESS) Mrs. Laura Karlstrom 816 N. Dodgion, Indep. Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lorimor, Iowa DATE 2-19- 1939

19. FUNERAL DIRECTOR (ADDRESS) H. W. Stahl. 815 W. Maple Ave. Indep. Mo.

20. FILED 2-20- 1939. F. L. Cook Local Registrar. 360

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Febr. 18, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from Feb 3 1935, to Feb 18, 1939
I last saw her alive on Feb 17, 1939. Death is said to have occurred on the date stated above, at 12:30A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
92 C	
Other contributory causes of importance:	
~~Hypostatic~~ Acute bronchitis	2-12-39
Hypostatic pneumonia	—

Name of operation None Date of
What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Russell Enthouse M.D., M. D.
(Address) Independence, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)