DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31483

Registration District No. 399 OCT 18 1939

Primary Registration District No. 1002

Registrar's No. 3581

1. PLACE OF DEATH:

(a) County Jackson 1

(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospl. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Jackson

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. 502 1/2 E. 15th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Charles E. Thurman 655

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan (Month) 5th (Day) 1867 (Year)

8. AGE: Years 62 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Franklyn County (City, town, or county) Mo (State or foreign country)

10. Usual occupation Salesman

11. Industry or business 0

FATHER
12. Name James C Thurman 0
13. Birthplace X (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Lucidia P Richardson
15. Birthplace X (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Mrs Mary Bullock

(b) Address St Joe Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-39 (Month) (Day) (Year)

(c) Place: burial or cremation St Joe Mo

18. (a) Signature of funeral director H. Pigerman & Son

(b) Address K.C. Mo

19. (a) 9-12-39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 9-10-39 year hour minute 1:30 P M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage (extradural)	
Due to Fracture of the skull	
Due to Auto traumatism 210 mt	
Other conditions (Include pregnancy within 3 months of death) 21	

Major findings:
Of operations ✓
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 9-9-39

(c) Where did injury occur? K.C. Mo 4 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Pedestrian struck by auto (Specify type of place)

While at work? (e) Means of injury

23. Signature Victor W Mahler (M. D. or other)

Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

50M-5-17-39
Rev. 5-17-39
I X19511

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

W. Tigerman & Son's

Signed By J. K. Tigerman

Licensed Embalmer No. .....

P. O. Address K. P. 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, above space should be left blank.