

Registration District No. 317 Primary Registration District No. 1602

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Manss City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 17 E. Main Hospitl
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Manss City
(If outside city or town limits, write "RURAL")
(d) Street No. 205 E. Front
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Wm Thurston
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Mar
6. (b) Name of husband or wife unk. 6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased no record
(Month) (Day) (Year)

8. AGE: Years 46 Months — Days — If less than one day hr. min.

9. Birthplace MO
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
12. Name James Thurston
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Emilia Melton
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Agnes Clark

(b) Address 17 E. Main Hospitl

17. (a) Burial (b) Date thereof 10/11/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W Washington

18. (a) Signature of funeral director Wm Washington

(b) Address Linwood & Main

19. (a) 10-11-39 (b) Wm Melton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1939 hour 7 minute 15 M.
21. I hereby certify that I attended the deceased from 5-39, 1939 to Oct 9-39, 1939
that I last saw him alive on Oct 9-39, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1
Due to 820
Due to

Other conditions Hypostatic
(Include pregnancy within 3 months of death)
Pneumonia

PHYSICIAN
Major findings:
Of operations
Of autopsy —
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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

23. Signature R T De Maria MD or other !
Address Santa Rosa Date signed 10-9-39

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.