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FILED JUL 12 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21184

State File No. ....

Registration District No. 72

Primary Registration District No. 4041

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Emma Allen Thomas

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased March 1 1871  
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 27 If less than one day hr. min.

9. Birthplace Boone Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Home Wife

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

MOTHER FATHER { 12. Name Hickman

13. Birthplace U. S.  
(City, town, or county) (State or foreign country)

14. Maiden name U. S.

15. Birthplace U. S.  
(City, town, or county) (State or foreign country)

16. (a) Informant Carl C. Thomas

(b) Address Centralia Mo

17. (a) Burial (b) Date thereof 9/30/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo. Burial

18. (a) Signature of funeral director Monahan

(b) Address Centralia Mo

19. (a) 929-1940 (b) F. J. Barden MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th year 1940 hour 6 minute 159 M.

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

Immediate cause of death Acute dilatation

Due to Chronic mgo cordite

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 92C

Major findings: Of operations \_\_\_\_\_

Of autopsy no

Duration

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) \_\_\_\_\_

(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? 1

(e) While at work? 36 (Specify type of place) (f) Manner of injury 2

23. Signature F. J. Barden MD (M.D. or other)

Address Columbia Mo Date signed 9/28/40

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

170

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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 *M. M. D. D. D.*  
Licensed Embalmer No. *2589*  
P. O. Address *Centralia 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.