

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7128
Registrar's No. 3

MAR 17 1941
Registration District No. 372

Primary Registration District No. 5546

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.

1. PLACE OF DEATH:

(a) County Iowa
(b) City or town Pilot Knob, Adair Co.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1
(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 LOYA MAGALÈNE THURMAN
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
7. Birth date of deceased Feb - 9 - 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days _____ If less than one day _____ hr. _____ min.
9. Birthplace Pilot Knob, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation none
11. Industry or business _____
MOTHER FATHER { 12. Name Del. S. Thurman
13. Birthplace Pilot Knob, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Orna May Chittum
15. Birthplace Wellington, Mo.
(City, town, or county) (State or foreign country)
16. (a) Informant's own signature Del. S. Thurman
(b) Address Pilot Knob, Mo.
17. (a) Burial (b) Date thereof Feb 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pilot Knob, Mo.
18. (a) Signature of funeral director N. R. White
(b) Address Ironton, Mo. by ad. white
19. (a) Feb 12 41 (b) L. J. Ellinger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Iowa #7
(c) City or town Pilot Knob
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 6
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 12, year 1941, hour 1:40 minute a M.
21. I hereby certify that I attended the deceased from 2-9-1941, to 2-12-1941; that I last saw her alive on 2-11-1941; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Unknown
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
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? 354
(Specify type of place) _____
(e) Means of injury _____
23. Signature F. W. Gale, M.D. (M. D. or other) _____
Address Bismarck, Mo. Date signed 2/14/41

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.