

## STANDARD CERTIFICATE OF DEATH

State File No. 17721

Registration District No. 287

Primary Registration District No. 4173

Registrar's No. 24

## 1. PLACE OF DEATH:

(a) County Stentlin  
 (b) City or town Malden  
 (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 3 yr. years, months or days

3. (a) PRINT FULL NAME Ray Selby Thomas3. (b) If veteran, name war L 3. (c) Social Security No. \_\_\_\_\_4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced U

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased Sep. 4th 1936  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
4 8 8 hr. min.9. Birthplace Leachville, Ark.  
(City, town, or county) (State or foreign country)10. Usual occupation Infant

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

12. Name Asa C. Thomas13. Birthplace Clay County, Ark.  
(City, town, or county) (State or foreign country)14. Maiden name Thelma Selby15. Birthplace Bernie, Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Asa Thomas(b) Address Malden, Mo.17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/41  
(Month) (Day) (Year)(c) Place: burial or cremation mailee ark.18. (a) Signature of funeral director H. H. Howard(b) Address Leachville, Ark.19. (a) 7-16-41 (Data received local registrar) (b) S. Mitchell (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin  
 (c) City or town Malden  
 (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 May day 12  
year 1941 hour 11 minute 25 P.M.21. I hereby certify that I attended the deceased from on  
May 12, 1941,  
that I last saw him alive on May 12, 1941,  
and that death occurred on the date and hour stated above.Immediate cause of death Jumor of Brain 552 Duration 1 yr.

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations in Oct. 1940 Part of tumor removed  
Of autopsy none

## 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? \_\_\_\_\_

(Specify type of place) (e) While at work? \_\_\_\_\_ (f) Means of injury 2.23. Signature H. D. Davis (M.D. or other) Do  
Address Malden Mo Date signed 5/16/41

59A

RECEIVED  
District Health Officer  
District File Number 641-6  
Date Filed 6/4/41

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..... *W. W. Howard*  
Licensed Embalmer No..... *3959*  
P. O. Address..... *Leachville, Va*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17721

Registration District No. 289

Primary Registration District No. 4173

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Malden  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ray Selby Thomas  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month May day 17  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M  
5. Color or race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

Immediate cause of death Tumor of Brain  
Due to M. M. D.  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 4 Months 8 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_ (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature H. D. Davis (M. D. or other)  
Address Malden Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-17721