FILED MAR 5 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8086
Do not use this space.

1. PLACE OF DEATH
(a) County Texas
(b) Township or (c) City Boone twp
Registration District No. 868
Primary Registration District No. 6150
Registered No. 33
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Madison Thurman
(a) Residence, No. On Route from Evening Shade
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Celia Thurman
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24 1908
7. AGE Years 33 Months 3 Days 18 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) Dec 1941
11. Total time (years) spent in this occupation 13

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poplar Bluff Mo

FATHER
13. NAME Arthur Thurman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poplar Bluff Mo

MOTHER
15. MAIDEN NAME Martha Russell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poplar Bluff Mo

17. INFORMANT (ADDRESS) Celia Thurman Evening Shade Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Bay Springs Cem DATE 12-14-41
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith + Ferguson Licking Mo
20. FILED 12/13 1941 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12 1941
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h... alive on ..... 19.... Death is said to have occurred on the date stated above, at 12:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
accidental death by gun shot self inflicted by self	

Other contributory causes of importance: 184-8 39

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 12-12 1941
Where did injury occur? Home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Near home
Manner of injury .....
Nature of injury .....
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) R. C. Sylvester M. D.
(Address) Houston Mo

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.

796 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 242282
Date Filed _____

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 Eubert E Ferguson

Licensed Embalmer No. 13945

P. O. Address Fickling Mo

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

If this body is not embalmed, above space should be left blank.

. No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8286

Registration District No. 868 Primary Registration District No. 6150 Registrar's No.

1. PLACE OF DEATH: (a) County Texas (b) City or town Rural (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 years, months or days) In this community

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 Madison Thurman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 24 (Day) 1908 (Year)

8. AGE: Years 33 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) 1/13/41 (Date received local registrar) (b) J. V. L. Reed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 12 year 1941 hour minute M.

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

Immediate cause of death — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY