

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Miami
(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 all her life years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1943 hour 8:00 minute 5:00 A.M.
21. I hereby certify that I attended the deceased from 10-29 1942 to 3-13 1943
that I last saw her alive on 3-13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 10 minutes

Due to Hypertension
Several years probably

Due to _____

Other conditions (Include pregnancy within 3 months of death) § 3a

Major findings: Of operations _____

Of autopsy _____

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 Off. Sullivan (M. D. or other) M.D.
Address Miami, Mo. Date signed 3/13/43

3. (a) PRINT FULL NAME ANNA THORNTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race black 6. (a) Single, widowed, married 2 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 Dec 15 1869 (Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Geo. Thomas

13. Birthplace Miami Saline Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Don't know

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

16. (a) Informant Frances Greene
(b) Address Malta Bend Mo

17. (a) _____ (b) Date thereof 3-15-43 (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation Miami

18. (a) Signature of funeral director Campbell Ewer
(b) Address Marshall Mo

19. (a) Mar 19 1943 (b) Mrs John Giger (Data received local registrar) (Registrar's signature)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

File Number

dated

4-7-43

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, ~~as by~~

Registered Apprentice No.

working under my personal supervision.

Signed

Jan. H. P. P. P.

Licensed Embalmer No. 1171

P. O. Address

Marshall

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.