S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27843

State File No.

Registration District No. 137 Primary Registration District No. 4217 Registrar's No. 143

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Urich Mo
(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 30 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry 42
(c) City or town Urich Mo
(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 Mary Elizabeth Thurston
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband ~~or wife~~ Joseph Grant Thurston
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 8 (Day) 1865 (Year)

8. AGE: Years 79 Months 6 Days 18 If less than one day hr. min.

9. Birthplace Nicholas Co. (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Housekeeping
11. Industry or business
FATHER
12. Name Abraham Feeback
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Sallie Ann Fuller
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Joe Thurston
(b) Address Urich Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Urich Cemetary
18. (a) Signature of funeral director W. J. Brown
(b) Address Urich Mo
19. Aug. 31, 1944 (Date received from registrar) Georgia Kitchen

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
year 1944 hour 3 P minute — P.M.
21. I hereby certify that I attended the deceased from Oct 1944, to Aug 26th, 1944
that I last saw her alive on Aug 26, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	18 hrs
Due to Arteriosclerosis with Hyp-tension	5 yrs?
Due to Cardio-Renal Disease	1 yr
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

131a

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)
While at work? (e) Means of injury
23. Signature J. G. McDonald (M. D. ~~or other~~)
Address Aug 29-44 Urich Date signed Mo

1004

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Di[illegible] Officer No. 7,
Di[illegible] 8-44-1063
Date Filed 9-11-44

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 R. R. Kennedy

Licensed Embalmer No. 3099

P. O. Address Clinton 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.