

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38935

State File No. _____

FILED DEC 13 1944

Registration District No. _____

Primary Registration District No. 3072

Registrar's No. 188

1. PLACE OF DEATH:
 (a) County Saline
 (b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
665 South Jefferson
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Saline 97
 (c) City or town Marshall 1
(If outside city or town limits, write "RURAL")
 (d) Street No. 665 South Jefferson 2
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

3. (a) PRINT FULL NAME Annettie Thomas
 3. (b) If veteran, name war _____ 3. (c) Social Security No. None
 4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife James M. Thomas 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 3rd, 1865
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov day 8
 year 1944 hour 12 minute 45A M.
 21. I hereby certify that I attended the deceased from _____ 1936 to Nov 8, 1944
 that I last saw ha alive on Nov 8, 1944
 and that death occurred on the date and hour stated above.

8. -AGE-
 Years 79 Months 5 Days 5
 If less than one day
 hr. _____ min. _____

Immediate cause of death Myocarditis - Shock
Fracture of hip
 Due to _____
 Due to _____

9. Birthplace West Virginia
(City, town, or county) (State or foreign country)
 10. Usual occupation None
 11. Industry or business _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name Eli F. Harmon
 13. Birthplace West Virginia
(City, town, or county) (State or foreign country)
 14. Maiden name Lucinda Griffith
 15. Birthplace West Virginia
(City, town, or county) (State or foreign country)
 16. (a) Informant E. F. Harmon
 (b) Address Marshall, Mo.
 17. (a) Burial (b) Date thereof Nov. 9, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hazel Grove cemetery
 18. (a) Signature of funeral director Charles E. ...
 (b) Address Marshall, Mo.
 19. (a) Nov. 18-44 (b) M. T. O. Westlock
(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?
(Specify type of place)
 While at work? _____ (b) Means of injury _____
 23. Signature John R. Lawrence (M. D. or other)
 Address Marshall Mo Date signed Nov 10, 1944

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

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

12-12-47

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. Campbell Jr.

Licensed Embalmer No.

3469

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

File File No. *see*
Registrar's No. *188*

Registration District No. *324* Primary Registration District No. *3072*

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

1. PLACE OF DEATH:

(a) County *Saline*

(b) City or town *Marshall*
(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)

3. (a) PRINT FULL NAME *Annette Thomas*

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 *w*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *June 3 1902*
(Month) (Day) (Year)

8. AGE: Years *49* Months *5* Days *11*
(Unless than one day)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* day *14* year *1944* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and the 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)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *accident - fall*

(b) Date of occurrence _____

(c) Where did injury occur? *home*
(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 *John R. Lawrence* (M. D. or other) _____
Address *Marshall, Mo* Date signed _____

SUPPLEMENTARY

38735

1911
1912
1913