

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12877

FILED FEB 15 1949

Registration District No. 371

Primary Registration District No. 4524

Registrar's No. 2

1. PLACE OF DEATH

(a) County Stoddard  
 (b) City or town Advance  
 (c) Name of hospital or institution None  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 500 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Stoddard  
 (c) City or town Advance  
 (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Infant Throuwer Daughter of  
 (b) If veteran, name war None  
 (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5  
 year 1948 hour 12 minute 52A M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced D  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Dec. 4, 1948  
 (Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u> hr. _____ min.

Immediate cause of death Pregnature, less than 7 months  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace Advance Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Infant

Other conditions (Include pregnancy within 3 months of death) 159

MOTHER FATHER  
 12. Name Lee R. Throuwer  
 13. Birthplace Charleston Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Wanda Lee  
 15. Birthplace Arkansas  
 (City, town, or county) (State or foreign country)

Major findings: Of operations 776X  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Lee R. Throuwer  
 (b) Address Advance, Mo.  
 17. (a) Burial Advance, Mo. (b) Date thereof Dec. 5, 1948  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Peter's  
 18. (a) Signature of funeral director Floyd S. Morgan  
 (b) Address Advance, Mo.  
 19. (a) 2-9-49 (b) Buried  
 (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 2  
 23. Signature E. G. Madus (M. D. or other) MD  
 Address Advance Mo. Date signed 1-18-49

RECEIVED

District Health Office NO. 2

District File Number 249-25

Date Filed 2-14-49

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.....

Not embalmed, Registered Apprentice No.....  
working under my personal supervision.

Signed Lloyd S. Morgan  
Licensed Embalmer No.....

P. O. Address.....

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

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