

FILED MAR 5 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7275

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 353 PRIMARY REG. DIST. NO. 6196 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <b>Texas</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Sherrell</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Sherrell 1070</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Thomas</b>	b. (Middle) <b>Lansford</b>	c. (Last) <b>Centrell</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>2-11-51</b>
-------------------------------------	--------------------------	-----------------------------	---------------------------	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb 20, 1899</b>	9. AGE (In years last birthday) <b>51-11-21</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--------------------	-------------------------------	---	--------------------------------------	---	--	---	--

13a. FATHER'S NAME <b>Starling Centrell</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Charleston</b>	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Nancy Jones - Licking Mo</b>	ADDRESS
---	-------------------------	--	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>apoplexy</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>334x</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>no</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <b>no</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Oct 1950** to **Feb 11, 1951**, that I last saw the deceased alive on **Feb 5, 1951**, and that death occurred at **12:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Lillie Barndall</b>	(Degree or title)	23b. ADDRESS <b>Licking Mo</b>	23c. DATE SIGNED <b>2/18/51</b>
--	-------------------	-----------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>2-13-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Licking Co</b>	24d. LOCATION (City, town, or county) (State) <b>Licking Mo</b>
--	-----------------------------	---	--

DATE REC'D BY LOCAL REG. <b>Feb 20, 1951</b>	REGISTRAR'S SIGNATURE <b>Elmora Hess</b>	324	25. FUNERAL DIRECTOR'S SIGNATURE <b>Smith</b>	ADDRESS <b>Licking Mo</b>
---	---	-----	--	------------------------------

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

1070

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED FEB 27 1957

Dist. File 25-422

Date Filed 2-27-57

---

---

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Eubert Ferguson*

Licensed Embalmer No. 3945

P. O. Address Licking 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.