

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **15461**

FILED JUN 7 1954

BIRTH NO. _____ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **88**

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY FRANKLIN	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WASHINGTON	a. STATE MO.	b. COUNTY FRANKLIN
c. LENGTH OF STAY (in this place) 5 HRS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WASHINGTON, MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSP		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) UNNAMED INFANT THURMOND	4. DATE OF DEATH (Month) (Day) (Year) MAY 31 1954
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT	8. DATE OF BIRTH MAY 30, 1954	9. AGE (In years last birthday) _____	# UNDER 1 Month _____	TEAR Days _____	# UNDER 4 Hrs. Hours 5	MIN. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) WASHINGTON, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME JOSEPH V. THURMOND	13b. MOTHER'S MAIDEN NAME AUDREY LAWRENCE	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Joseph Thurmond, Sullivan Mo	ADDRESS _____
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) not determined 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 770 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 5-30, 1954, to 5-30, 1954, that I last saw the deceased alive on 5-30, 1954, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. M. Mearns, M.D.	23b. ADDRESS 905 E. Washington	23c. DATE SIGNED 5-31-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JUN 21, 1954	24c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY	24d. LOCATION (City, town, or county) (State) SULLIVAN P.R.I. MO.
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DATE REC'D BY LOCAL REG. 6/2/54	REGISTRAR'S SIGNATURE J. Mearns	52-0	25. FUNERAL DIRECTOR'S SIGNATURE H. Mearns	ADDRESS Sullivan, Mo.
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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 _____

H. M. Eaton

Licensed Embalmer No. _____

4192

P. O. Address _____

Sullivan, 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.