

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

18466

State File No.

BIRTH NO. 42311-54 REG. DIST. NO. 104 PRIMARY REG. DIST. NO. 4176 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Parents Malden</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Malden Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural -</u> <u>0720</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Carlstrom Clinic</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	

3. NAME OF DECEASED a. (First) <u>Frank Thonda</u> b. (Middle) <u>Rose</u> c. (Last) <u>Montgomery</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 19-1954</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>June 19-1954</u>	9. AGE (In years last birthday) <u>20</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	

13a. FATHER'S NAME <u>Claude Lee Montgomery</u>		13b. MOTHER'S MAIDEN NAME <u>Elsoner Ellama Baker</u>		14. NAME OF HUSBAND OR WIFE <u>1</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lilya Faye Baker Malden Mo</u>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>776x</u>
	DUE TO (b) <u>Post 4 1/2 mo</u>		
	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		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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.		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 July 19, 1954, to July 19, 1954 that I last saw the deceased alive on July 19, 1954 and that death occurred at _____ m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. D. Schurman D.O.</u>		23b. ADDRESS <u>Malden Mo</u>		23c. DATE SIGNED <u>July 19 54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-19-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Hilliard Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>South of Malden Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>none</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>June 23-54</u>		REGISTRAR'S SIGNATURE <u>J. D. Schurman</u> <u>87-0</u>			

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

RECEIVED DUNKLIN COUNTY HEA

DEPARTMENT..... 7-18-57

COUNTY FILE NUMBER 754-

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* _____

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.