

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033947

STATE FILE NUMBER

FILED OCT 14 1958

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 374

5. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Francois		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp. Farmington - rural		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Bonne Terre		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Thomas Dell Home		Length of stay in lb 7 Weeks	d. STREET ADDRESS (If outside, give location) 54 W School		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY ISABELL THOMURE			4. DATE OF DEATH Month Day Year Oct 1 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 8 1877	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Day(s) Months Days Hours Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Ste Genevieve, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Felix Lalumandiere		13b. MOTHER'S MAIDEN NAME Julia Bell		14. NAME OF HUSBAND OR WIFE Lawrence Thomure	
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. None	17. INFORMANT Address Mrs Ernest Stretesky Bonne Terre Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) 4200 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 8-17-58 to 10-1-58 and last saw her alive on 10-1-58 . Death occurred at 2:20 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) C. E. Carleton, M.D.			22b. ADDRESS Farmington Mo		22c. DATE SIGNED 10-3-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 4 1958	23c. NAME OF CEMETERY OR CREMATORY St Josephs Catholic		23d. LOCATION (City, town, or county) (State) Bonne Terre Mo
24. FUNERAL DIRECTOR BOYER & SON Bonne Terre Mo			25. DATE RECD. BY LOCAL REG. Oct. 3, 1958		26. REGISTRAR'S SIGNATURE Esther Rudloff

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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
Signature of Student Embalmer

Signed *B. T. Boyer*

Licensed Embalmer No. *3660*

P. O. Address *Albany, N.Y.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.