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. Health,
& Welfare
. Public
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 59 Primary Registration District No. 5227 Registrar's No. 17

1. PLACE OF DEATH
a. COUNTY: Cass
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Harrisonville — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Pleasant View Rest Home — Length of stay in 1b: 4 months.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Barton
c. CITY OR TOWN: Lamar — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 7 miles south — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Fannie Middle: Mattie Last: Thornburg

4. DATE OF DEATH: Month 1 Day 9 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1877
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Creighton, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: J. B. Cornett
13b. MOTHER'S MAIDEN NAME: Elizabeth Page
14. NAME OF HUSBAND OR WIFE: Oswell O. Thornburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Marion Thornburg Address: Adrian, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF STOMACH — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): BRONCHOPNEUMONIA 151 X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 SEPT 1958, to JAN 9 1959 and last saw her/him alive on JAN. 6 1959
Death occurred at 12:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.
22b. ADDRESS: HARRISONVILLE Mo
22c. DATE SIGNED: 1-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 11, 1959
23c. NAME OF CEMETERY OR CREMATORY: Byler Cemetery
23d. LOCATION (City, town, or county) (State): Creighton, Missouri

24. FUNERAL DIRECTOR: Atkinson-Hickey ADDRESS: Garden City, Mo.
25. DATE RECD. BY LOCAL REG.: 1-13-59
26. REGISTRAR'S SIGNATURE: Mrs Ray Sebree

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

HEALTH DEPARTMENT

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 Billy J. Lickey

Licensed Embalmer No. 4695

P. O. Address Shelby City, M

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.