

FD-44
No. 2
11-10-39
5-17-39
K21492

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 139

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

1. PLACE OF DEATH:
 (a) County St. Francois Co
 (b) City or town Rural St. Francois
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Francois
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

In this community _____ years, months or days
3. (a) PRINT FULL NAME Laura Luise Thurman
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 31 year 1940 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from 7-3-40 19____, to 7-31-40, 19____; that I last saw her alive on 7-31-40, 19____; and that death occurred on the date and hour stated above.

4. Sex Female **5. Color or race** White
6. (a) Single, widowed, married, divorced, married

Immediate cause of death. Cerebral thrombosis
9 hypertension
Cerebrovascular disease
 Due to _____
 Due to _____

6. (b) Name of husband or wife Frank Thurman
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased. Aug 15th 1879
 (Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 16 If less than one day _____ hr. _____ min.

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
 Of operations _____
 Of autopsy _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

9. Birthplace St. Genevieve Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Morgan P. Smith
13. Birthplace Ind.
 (City, town, or county) (State or foreign country)
14. Maiden name Louise Westraut
15. Birthplace St. Genevieve Co Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Frank Thurman
(b) Address Farmington Mo

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(e) Means of injury _____ (Specify type of place)
23. Signature Philip C. ... M.D. or other _____
Address Farmington Mo Date signed 8-3-40

17. (a) Burial _____ (Burial, cremation, or removal)
(b) Date thereof 8-3-40 (Month) (Day) (Year)
(c) Place: burial or cremation St. V. A. Three Rivers Cemetery

18. (a) Signature of funeral director Flat River Mo
(b) Address _____

19. (a) Aug 1-40 (Date received local registrar)
(b) T. J. Robinson (Registrar's signature)

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.