MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 13070
Registered No. 4

1. PLACE OF DEATH
County: Andrew — Registration District No. 11
Township: Jackson — Primary Registration District No. 5015
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ella P. Thorburn

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 21 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 9-1931

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	

8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Andrew Co.
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Clarence Thorburn
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Fern Bannan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Andrew Co. Mo.

14. INFORMANT Clarence Thorburn
(Address) Fillmore Mo.

15. FILED 4-12 1931 C. W. Cole REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-11 1931

17. I HEREBY CERTIFY, That I attended deceased from 4-9 ....., 1931, to 4-11 ....., 1931 that I last saw h. alive on 4-11 ....., 1931, and that death occurred, on the date stated above, at 7 P.M. ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Lab
(Signed) M. L. Holliday, M. D.
..... 19 (Address) Fillmore Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Fillmore Mo	4-12 1931
20. UNDERTAKER	**ADDRESS**
C. W. Cole	Fillmore Mo.