

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

Do not use this space.

26874

1. PLACE OF DEATH

County Ray
Township Sullivan
City Marion, Mo

Registration District No. 26
Primary Registration District No. 3002

File No. _____
Registered No. 111
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7 - 1905

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>24</u>	<u>5</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Robber Brick Plant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mexico
(STATE OR COUNTRY) mo.

10. NAME OF FATHER Clay Thompson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Florida
(STATE OR COUNTRY) mo.

12. MAIDEN NAME OF MOTHER Annie May

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

14. INFORMANT Stacy Thompson
(Address) Mexico mo.

15. FILED Aug 26 1929 Ira S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 24, 1929 that I last saw him alive on Aug 24, 1929, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuber culosis of Lung.
23A
11A

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

18. WHERE WAS DISEASE CONTRACTED 31
IF NOT AT PLACE OF DEATH _____ (duration) yrs. mos. ds.

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. F. Toole, M. D.
, 19 (Address) Mexico 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 Mexico mo. DATE OF BURIAL Aug 26 1929

20. UNDERTAKER McPherson ADDRESS Mexico mo.

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.

PERMANENT RECORD

