

REC'D JUL 25 1938

MISSOURI STATE BOARD OF HEALTH.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

23088

Do not use this space.

1. PLACE OF DEATH

(a) County Shannon. Registration District No. 825-
 (b) Township Spring Creek. Primary Registration District No. 6044
 (c) City Mountain View Mo. (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Mt. View Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE of Jona Thompson.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 13-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 - 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

13. NAME John Thompson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vermont

15. MAIDEN NAME Not known.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known.

17. INFORMANT (NAME) H. O. Thompson.

18. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mountain View Mo.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Amman.

20. FILED June 4, 1938 Mountain View Mo.

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 3, 1938

22. I HEREBY CERTIFY, That I attended deceased from May 4, 1938, to June 3, 1938

I last saw him alive on May 18, 1938. Death is said to have occurred on the date stated above, at 2:15 P. M.

The principal cause of death and related causes of importance were as follows:

Valvular insufficiency

Other contributory causes of importance: 924

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Rob. Davis, M. D.

(Address) Over Tree Mo.

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.