

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

10782
 Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 241
 (b) Township W. Benton Primary Registration District No. 5334
 (c) City _____ or _____
 (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) 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

512 Alice Adeline Thompson
 (a) Residence, No. _____ 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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. A. Thompson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 19-1859
 7. AGE YEARS 81 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Housekeeper
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME John Hobson

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

MOTHER 15. MAIDEN NAME Emily Good

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Jim Whitney
Wellington Kans.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hone Rock DATE 2-18 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. B. Jones
Buffalo Mo

20. FILED 5/20 1940 Hanny Morrow
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16 1940
 I HEREBY CERTIFY That I attended deceased from 2-8 - 1940 to 2-16 - 1940
 I last saw her alive on 2-12 - 1940 Death is said to have occurred on the date stated above, at 9:20 a m.
 The principal cause of death and related causes of importance were as follows:

Influenza
59
 Other contributory causes of importance:
Diabetes Mellitus
Several yrs

Name of operation _____ Date of _____
 What test confirmed diagnosis? usual Was there an autopsy? no

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? no
 If so, specify _____
 (Signed) H. B. Jones, M. D.
5/18 (Address) _____

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

RECEIVED
District Health Officer No. 7,
District File Number H-40-5-19
Date Filed H-1-16

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 10782

Registration District No. 241

Primary Registration District No. 5-334

Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Benton rural
(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.
In this community. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. no (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME

Alice Adline Thompson

4. MEDICAL CERTIFICATION

3. (b) If veteran, name war. 3. (c) Social Security No.

20. DATE OF DEATH: Month 2 day 6 year hour minute M.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married divorced wed
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

8. AGE: Years 81 Months Days If less than one day hr. min.

Due to. Due to. Other conditions. (Include pregnancy within 3 months of death) Major findings: Of operations. Of autopsy.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (b) Date thereof. (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) (b) (Date received local registrar) (Registrar's signature)

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature W. C. Plummer (M: D. or other)

Address Buffalo Mo signed

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

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-10782

1940