

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 13 1940

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

14378
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township 3 Primary Registration District No. 001 Registered No. 469
 (c) City St. Joseph, Mo. (d) Street No. State Hospital for Insane # 2 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 12 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Frank E. Thompson

(a) Residence, No. R. F. D. # 5, St. Joseph, 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Stella Quaney Thompson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-22-87

7. AGE YEARS 53 MONTHS 0 DAYS 1 If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Fireman on C. B. & Q.
 9. Industry or business in which work also farmer. was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) April 23, 1940 on R. F. D. # 5 11. Total time (years) spent in this occupation 13 yrs on R. F. D.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fairfax, Missouri

FATHER 13. NAME John Thompson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Louisiana, 1

MOTHER 15. MAIDEN NAME Katherine Magers,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Missouri, 0

17. INFORMANT (ADDRESS) State Hospital Records St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet Cem. DATE April 25, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter Bowman Funeral 319 So. 10th. Str

20. FILED 4/25 1940 A. J. Westbach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 23, 1940

22. I HEREBY CERTIFY, That I attended deceased from 1:30 a.m. April 23, 1940, to 3 A.M. April 23, 1940
 I last saw him alive on April 23, 1940. Death is said to have occurred on the date stated above, at 3:00 m. A.M.
 The principal cause of death and related causes of importance were as follows:

Heart failure as result of
coronary artery disease
chronic arteriosclerosis
taking pills July 3 last before death
 Date of onset 96
 Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? yes

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) P. S. Tate, M. D.
 Address State Hosp. # 2 St Joseph 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 *W. M. Summerfield*

Licensed Embalmer No. *69007*

P. O. Address *319 So. 10th Street*

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.