DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 15 1940

Registration District No. 3[illegible]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35412

Primary Registration District No. 3434A

Registrar's No.

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Galt Rural Marion
(If outside city or town limits, write "RURAL" and name of township)

(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 2 (Specify whether
In this community 67 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Grundy

(c) City or town Galt "Rural" Marion Rup
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME HARRY HARRISON THOMAS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 12 (Month) 22 (Day) 1872 (Year)

8. AGE: Years 67 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Alpha Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Painter 1

11. Industry or business

FATHER
12. Name James P Thomas 1
13. Birthplace Dont Know (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Catharine Mangold
15. Birthplace Dont Know (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Jirpie Campbell
(b) Address Galt Mo RFD 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Laredo Cemetery

18. (a) Signature of funeral director E. J. Robertson
(b) Address Laredo Mo.

19. (a) October 25 1940 (Date received local registrar) Mabel Warren (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5
year 1940 hour 8.30 minute P M.

21. I hereby certify that I attended the deceased from 11-18, 1939 to 10-5, 1940
that I last saw him alive on 10-5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of Right Infarction Vein

Due to

Due to

Other conditions Renal Calculus
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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? None (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 959 (Specify type of place)
While at work? No (e) Means of injury

23. Signature [illegible] (M. D. or other) [illegible]
Address Laredo Date signed 10-7-4

(Licensed Embalmer's Statement on Reverse Side)

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

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. E. J. Robertson

Licensed Embalmer No. 2468

P. O. Address. Laredo, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35-412

Registration District No. 329 Primary Registration District No. 3454A Registrar's No.

1. PLACE OF DEATH

(a) County Grundy

(b) City or town Marion T.P.
(If outside city or town limits write "RURAL" and name of township)

(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 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Harry Harrison Thomas

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of Sub Clavical Vein — Duration

Due to Severe straining doing an attempt to have a movement from bowels,

Due to

Other conditions Renal Calculus
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

144 B' 11'

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature Roy J. Gay M.D. (M. D. or other)
Address Laredo Mo. Date signed 1-11-41

SUPPLEMENTARY