

FILED MAY 18 1942

Registration District No. _____

Primary Registration District No. 3008

Registrar's No. 142

1. PLACE OF DEATH: *Callaway*

(a) County *Callaway*

(b) City or town *Palmyra*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *State Hospital No. 12*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *29d.*
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Marion*

(c) City or town *Palmyra*
(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 *Benjamin L. Thomas*

3. (b) If veteran, name war *DK.*

3. (c) Social Security No. *DK.*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Apr* day *30*
year *1942* hour *11-30* minute *0* M.

4. Sex *M* 5. Color or race *W*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: *Aug* (Month) *2* (Day) *1881* (Year)

21. I hereby certify that I attended the deceased from *4/28/1942* to *4/30/1942*
that I last saw him alive on *4/29/1942*
and that death occurred on the date and hour stated above.

8. AGE: Years *60* Months *8* Days *28*
If less than one day hr. _____ min.

Immediate cause of death *Chronic Poison*

Due to *Chronic Nephritis*

9. Birthplace *Marion Co Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *Laborer*

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name *Ben Thomas*

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

Major findings: _____
Of operations _____

Of autopsy _____

14. Maiden name *DK.*

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

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

17. (a) ~~REMOVAL~~ (b) Date thereof *5-1-42*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Palmyra Mo.*

18. (a) Signature of funeral director *E. J. Sprague*

(b) Address *Palmyra Mo.*

19. (a) *5-1-42* (b) *Joel Moscuthoff*
(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 *George W. Deuss* (M. D. or other) *M.D.*

Address *Palmyra Mo* Date signed *4/30/42*

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

14
1
2

p

109 W. 7th

Mansin to Hoff.

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. 3245

P. O. Address Palmyra, Mo

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, fact should be so stated above.