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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37553

FILED DEC 9 1942
Registration District No. 198

Primary Registration District No. 4310

State File No.

Registrar's No. 13

61
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Bever
(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 Mo (b) County Macon

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

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

(e) Citizen of foreign country? yes (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gomer L. Thomas

3. (b) If veteran, name war ✓

3. (c) Social Security No. 1 ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year 1942 hour _____ minute _____ M.

4. Sex Male 5. Color or race Caucas

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

6. (b) Name of husband or wife Elly Thomas 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased: (Month) 9 (Day) 29 (Year) 1900

21. I hereby certify that I attended the deceased from 9/30, 1941, to 10/23/42
that I last saw him alive on 10/23, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of recto sigmoid reg. of Colau

Due to _____

Due to H62

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

Duration 15 mo

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

8. AGE: Years 72 Months 0 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation: Merchant

11. Industry or business: Rowland Thomas

12. Name: So-wales

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

14. Maiden name: Margaret Davis

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

16. (a) Informant: Elizabeth Thomas

(b) Address: Bever Mo

17. (a) Burial (b) Date thereof: 10-25-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: East chapel

Major findings: Impassible recto sigmoid carcinoma resected one year ago

Of operations _____

Of autopsy _____

18. (a) Signature of funeral director: J. S. Edwards

(b) Address: Bever Mo

19. (a) 11-10-42 (b) Winnie J. Rowland
(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) (c) Means of injury _____

23. Signature: J. P. [unclear] (M. D. or other) _____
Address: Macon Mo Date signed: 10/28/42

1287 (Licensed Embalmer's Statement on Reverse Side)

REC 9 1942

RECEIVED

District Health Officer No. 10¹

District File Number 12-42-3084

Date Filed DEC - 7 1942

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 *J. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address Beris, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37553

Registration District No. 199

Primary Registration District No. 4310

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Bevier
(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 mo (b) County macon
(c) City or town Bevier
(If outside city or town limits, write "RURAL")
(d) Street No. 7. Kinn St.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gomer L 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 m

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

7. Birth date of deceased Sept 29 1920
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days _____ (If less than one day) _____ min.

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I first saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

