No. 2
-1-4-41
-17-39
X26390

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. 6993

FILED FEB 28 1944

Registration District No. ~~126~~ 89 Primary Registration District No. ~~2000~~ 5328 Registrar's No. 378

1. PLACE OF DEATH:

(a) County ~~GREENE~~ Crawford

(b) City or town ~~Springfield~~ Fr. Cr. Ty. Lin.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Frisco R.R. stway near Leasburg Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County GREENE 39

(c) City or town SPRINGFIELD 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2450 N. CAMPBELL 6
(If rural, give location)

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

3. (a) PRINT FULL NAME ROBERT E. THOMPSON

3. (b) If veteran, name war W.W. 1

3. (c) Social Security No. 496-10-5629

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife HELEN THOMPSON

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Aug (Month) 25 (Day) 1895 (Year)

8. AGE: Years 48 Months 4 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation R.R. Worker

11. Industry or business

FATHER
12. Name B.W. THOMPSON
13. Birthplace WIS. / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name SARAH M. PIKE
15. Birthplace IND. / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helen Thompson
(b) Address Springfield, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10-1944 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director J.W. Klingner & Co.
(b) Address

19. (a) Feb 15, 44 (Date received local registrar) (b) W. F. Irwin M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day Jan year 1944 hour 8 minute 30 A.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 accidentally Killed by train. Body badly mutilated. Skull fractured and entire body broken and crushed. ✓ /

Due to ✓

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) 728 /
(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 3

23. Signature Walter Probate Judge (M. D. or other)
Address Dulwich Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

169-6

RECEIVED
District Health Officer No 5,
District File Number 2441.62
Date Filed 2-21-43

FEB 24 1944

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 89 Primary Registration District No. 5328 Registrar's No. 373

1. PLACE OF DEATH:

(a) County: Crawford

(b) City or town: Liberty Twp. (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 years, months or days) In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Robert E. Thompson

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: Aug (Month) 25 (Day) 1899 (Year)

8. AGE: Years 48 Months 4 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (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 Jan Day 4 year 1944 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: Accidentally Killed by train. Body badly mutilated.

Due to: Skull fractured and entire body broken and

Due to: Crushed

Other conditions (Include pregnancy within 3 months of death)

Major findings Of operations

Of autopsy

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) Accident

(b) Date of occurrence Jan. 4-1944

(c) Where did injury occur? Leasburg (City or town) Crawford (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On R.R.

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

23. Signature C. Hattman Probate Judge (M.D. or other)

Address acting Coroner Date signed

Steelville Mo.

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

169-6

6993

MAR - 2 1945