

FILED APR 20 1944
Registration District No.

Primary Registration District No. 5412

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Ava Rural Springcreek Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas 39

(c) City or town Ava Rural
(If outside city or town limits, write "RURAL") 0

(d) Street No. Route 4
(If rural, give location) 0

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

3. (a) PRINT FULL NAME Mahalie F. Thompson

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

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 28
year 1944 hour 8 minute 20 P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James Thompson

6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased August 30, 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1940 to July 25 1944
that I last saw her alive on July 25 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Valvular Heart Disease

Duration 4 days
9-2

8. AGE: Years Months Days If less than one day
85 6 28 hr. min.

Due to.....

Due to.....

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

9. Birthplace Squires, Missouri 0
(City, town, or county) (State or foreign country)

Major findings:
Of operations.....

Of autopsy.....

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name M. Robertson

13. Birthplace Unknown Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ross,

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

16. (a) Informant Joseph Thompson

(b) Address 13520 Broadway Kansas City

17. (a) Burial (b) Date thereof March 2, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fannon

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) (e) Means of injury.....

23. Signature R. M. Morrison (M. D. or other)
Address Ava Mo Date signed Mar 4

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Missouri

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

1056

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

A. P. M. Norman

RECEIVED

District Health Officer No. 6,

District File Number 444-483-

Date Filled APR 18 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.....

W. B. Hutchinson

Licensed Embalmer No.....

3431

P. O. Address.....

Over Mo

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 24

Registration District No. 101

Primary Registration District No. 042

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Rural Spring Creek
(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 85 yr (years, months or days)

3. (a) PRINT FULL NAME Mahalee F. Thompson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 30 (Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 15 (less than one day) min.

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

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 14-1-1944 (b) Mrs. J. R. Spurlock
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28 year 1944 hour _____ minute _____ M.

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

14562