U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 8 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2265

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 82

1. PLACE OF DEATH:

(a) County: GREENE
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 6 day (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Oregon
(c) City or town: Koshkonong
(If outside city or town limits, write "RURAL")
(d) Street No.: Route 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Thomas - Earl.
3. (b) If veteran, name war: # 2.
3. (c) Social Security No.: UNK.
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: X years
7. Birth date of deceased: Feb. (Month) 11 (Day) 1925 (Year)

8. AGE: Years 19 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace: West Plains (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Farming.
11. Industry or business:
12. Name (Father): James M. Thomas.
13. Birthplace (Father): Salem (City, town, or county) Ark. (State or foreign country)
14. Maiden name (Mother): Lula Osborn.
15. Birthplace (Mother): Salem (City, town, or county) Ark. (State or foreign country)
16. (a) Informant: Ethel Hall (Aunt)
(b) Address: St. Louis, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Hatfield, Mo.
18. (a) Signature of funeral director: Alma Clinger
(b) Address: Springfield, Mo.
19. (a) 1-27-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: January day: 25 year: 1945 hour: 5:15 minute: A.M.
21. I hereby certify that I attended the deceased from 1/19/45 to 1/25/45, 19 45, that I last saw him alive on 1/24, 19 45, and that death occurred on the date and hour stated above.

Immediate cause of death: Obstruction of colon — 2 days
Due to: Carcinoma of colon (splenic area) —
Due to:
Other conditions: 4 days
(Include pregnancy within 3 months of death)

Major findings: Of operations: Carcinoma — (Colostomy)
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):
(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: Guy D. Callaway (M. D. or other) MD
Address: Springfield, Mo. Date signed: 1/27/45

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 28 1945

JAN 16 1946

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 Harlow Krabb

Licensed Embalmer No. 4065

P. O. Address Springfield 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.