

Registration District No. 59

Primary Registration District No. 5219

Registrar's No. 57

900

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

1. PLACE OF DEATH:

(a) County Cass Co. Mo.  
(b) City or town East Lynne (Rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Camp Branch Hosp  
(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

8. (a) PRINT FULL NAME IDA MAY THOMSON

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Aug 19 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Wm Mum

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

14. Maiden name Sarah Shumate

15. Birthplace Cass Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Thomson

(b) Address Grand View Mo

17. (a) Burial (b) Date thereof 4-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pitto Chapel

18. (a) Signature of funeral director J. A. H. Hartler

(b) Address East Lynne Mo

19. (a) April 20, 1945 (b) Margaret Valle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass  
(c) City or town East Lynne (Rural)  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 9  
year 1945 hour 2 minute 9 M.

21. I hereby certify that I attended the deceased from Jan. 24 1944 to Apr. 8 1945  
that I last saw her alive on Apr. 8 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Embolism  
(Cerebral Embolism) Duration 2 days  
Due to Mitral Regurgitation 16 yrs.  
(Mitral Regurgitation)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations gsw  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature J. S. Triplett M.D. (M. D. or other)  
Address Harrisville Mo. Date signed 4/17/45

*[Faint, illegible text]*

**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 *G. D. Herbert*

Licensed Embalmer No. *2767*

P. O. Address *East Lyme, N.H.*

**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, above space should be left blank.**