

No. 2
-9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23618

State File No.

FILED AUG 9 1945

Registration District No.

Primary Registration District No. 3008

Registrar's No. 214

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Callaway
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 9 Mo - 18d
(Specify whether
In this community 9 Mo - 18d
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Schuyler
(c) City or town Queen City
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Madison 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 Married
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 47 1/2 years
7. Birth date of deceased: Sept 8 - 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 9 22 hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name George R. Thomas
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Georgia Mary Casey
15. Birthplace Virginia 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eva Thomas
(b) Address Queen City, Mo.

17. (a) Removal (b) Date thereof 7/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurester, Mo.

18. (a) Signature of funeral director Wallace Funeral Home
(b) Address Fulton, Mo. (D.C. Browning Hwy)

19. (a) 7-5-1945 (b) Josie Mossickoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1945 hour 3:20 minute P M.

21. I hereby certify that I attended the deceased from 9-23 1944 to 6-30 1945
that I last saw him alive on 6-30 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 5d

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations 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?

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

23. Signature George R. Reeves (M. D. or other) MD
J. B. Stahl Fulton Date signed 8/30/45

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 8-7-45

APR 3 1950

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 Denzil C. Browning

Licensed Embalmer No. 27 24

P. O. Address Fulton Md

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 204

Registration District No. 47 Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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)

3. (a) PRINT FULL NAME Madison C 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 85 years

7. Birth date of deceased Sept 8 (Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 15 If less than one day hr. min.

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

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)

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 Sept year 1948 hour minute M.

21. I hereby certify that I attended the deceased from to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death. Duration

Due to Lobar Pneumonia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

108

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) (c) Means of injury.

23. Signature George W. Peers (M. D. or other) Address Fulton Mo Date signed 8/11/48

23016