

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4768**

Registration District No. **46**

Primary Registration District No. **4066**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Caldwell**
(b) City or town **Kingston**
(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 years, months or days)

3. (a) PRINT FULL NAME **Thomas Stocton Virtue**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 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 **January 17 1873**
(Month) (Day) (Year)

8. AGE: Years **73** Months **I** Days **2** If less than one day _____ hr. _____ min.

9. Birthplace **Burgettstown Pa.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Thomas Stocton**
13. Birthplace **Pa.**
14. Maiden name **Rachel Jane Vance**
15. Birthplace **Pa.**

16. (a) Informant **Hugh R. Virtue**

(b) Address **4711 Grand Kansas City, Mo**

17. (a) **Burial** (b) Date thereof **2-22-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mirabile Cemetery**

18. (a) Signature of funeral director **Cramer Clark**

(b) Address **Kingston, Missouri**

19. (a) **Feb 12 1946** (b) **Glady's Jones**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Caldwell** 13
(c) City or town **Kingston** 8
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? **NO** (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mont **Feb** day **19** 14
year **1946** hour **3** min **P.** M.

21. I hereby certify that I attended the deceased from **Feb 6 to Feb 19 1946**
and that I last saw him alive on **Feb 19 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **Hypertension** Duration **abt 9 days**

Due to **Arteriosclerosis**
Other conditions **Hemiplegia Right side**

Major findings:
Of operations _____
Of autopsy **gsw**
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) (e) Means of injury _____

23. Signature **W. S. Shouse** (M. D. or other) 0
Address **Kingston Mo** Date signed **2-21-46**

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

3730

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 Cramer Clark

Licensed Embalmer No. 3257

P. O. Address Kingston, 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.