

5. No. 2
A-5-42
5-17-39
P I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9207**
Registrar's No. **58**

FILED APR 15 1946

Registration District No. **133** Primary Registration District No. **5139**

1. PLACE OF DEATH:
(a) County **Holt.**
(b) City or town **Rural Minton Twp.**
(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)

2. USUAL RESIDENCE OF DECEASED:
Missouri Holt 44
(a) State _____ (b) County _____
(c) City or town **Bigelow. Mo. Rural.**
(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 **Dr. Charles Harvey Thomas.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **22**
year **1946** hour **5** minute **P.M.** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **208 Minton Thomas.** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **March 8 1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 23**, 19**46**, to **March 23**, 19**46**
that I last saw him alive on **March 22**, 19**46**
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **0** Days **14**
If less than one day _____ hr. _____ min.

Immediate cause of death **Endocarditis**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace **West Cario Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **M.D.**

11. Industry or business _____
12. Name **David D Thomas.**
13. Birthplace **Wales. 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Jane Ward.**
15. Birthplace **West Cario. Ohio.**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
9207

16. (a) Informant **Dr. J. E. Hoag**
(b) Address **Bigelow. Mo.**
17. (a) **Burial** (b) Date thereof **3/25.46.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **W. Crawford**
18. (a) Signature of funeral director **W. Crawford**
(b) Address **Mound City. Mo.**
19. (a) **9-25-46** (b) **J. Hoag**
(Date received local registrar) (Registrar's signature)

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. E. Hoag** (M.D. or other) _____
Address **Mound City Mo** Date signed **3/25/46**

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

SEP 27 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. H. Crawford*
Licensed Embalmer No. *1824*
P. O. Address *Maud City 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.