

FILED APR 11 1946

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 99

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Hospital No. 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 YRS. 6 MOS.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger 94
(c) City or town Scopus ?
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME IDA THOMAS

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Separated

6. (b) Name of husband or wife Thomas 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 or 8 Days Unk. If less than one day hr. _____ min. _____

9. Birthplace Bollinger County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name C. M. Craig
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Adeline Oakes
15. Birthplace Bollinger Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 3-21-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington

18. (a) Signature of funeral director C. H. Cozean
(b) Address Farmington, Missouri

19. (a) 3/21/46 (b) Ether Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. 16 day _____
year 1946 hour 8 minute 25 M.

21. I hereby certify that I attended the deceased from Sept. 16, 1944 to Mar. 16, 1946
(that I last saw her alive on Mar. 16, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis 1 yr

Due to 938

Due to Central Arteriosclerosis
Psychosis with eye
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Chr. Myocarditis

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? 1, MO.

While at work? _____ (Specify type of place)
Means of injury 0

23. Signature James Doctor (M. D. or other) _____
Address Farmington Date signed 3/16/46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 446-199.2
Date Filed 4-10-46

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.

not embalmed

Signed *C. Cozart*

Licensed Embalmer No. 4084

P. O. Address Farmington

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.