

FILED

SEP 5 1946

Registration District No. 147

Primary Registration District No. 4731

State File No. \_\_\_\_\_

Registrar's No. 48

## 1. PLACE OF DEATH:

(a) County Howell  
 (b) City or town Mountain View  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
None  
 (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) 1 year

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell 46  
 (c) City or town Mountain View 0  
 (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 \_\_\_\_\_

3. (a) PRINT FULL NAME MINNIE Thompson3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife James W. Thompson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Apr. 11 1870  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>3</u>	<u>5</u>	_____ hr. _____ min.

9. Birthplace not known  
(City, town, or county) (State or foreign country)10. Usual occupation School Teacher

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

12. Name M<sup>rs</sup> G. H. \_\_\_\_\_13. Birthplace Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace 9  
(City, town, or county) (State or foreign country)16. (a) Informant MRS Lillie Simpson(b) Address Mountain View, Mo.17. (a) Burial (b) Date thereof 7 21 46  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hutton Valley18. (a) Signature of funeral director Joe R. Duncan(b) Address mt. view, Mo.19. (a) Aug-21-46 (b) Laura Mitchell  
(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16  
year 1946 hour 8 minute A.M.21. I hereby certify that I attended the deceased from Jan  
1946 to July 5 1946  
that I last saw him alive on July 30 1946  
and that death occurred on the date and hour stated above.Immediate cause of death Coronary Occlusion Duration \_\_\_\_\_Due to BREAST

Due to \_\_\_\_\_

Other conditions:  
(Include pregnancy within 3 months of death)Major findings:  
Of operations 94a

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 223. Signature Stanley Bassen (M. D. or other) DDAddress Mountain View Date signed 7-26-46

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(Licensed Embalmer's Statement on Reverse Side)

**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 *Joe E. Duncanson*

Licensed Embalmer No. *4325*

P. O. Address *Intervenor, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 142

Primary Registration District No. 4231

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Haskell  
(b) City or town Mountain View  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Murrel Thompson

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

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased April (Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Day \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPERSEMENTARY

WHILE PRINTING—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

26987