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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1947

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8141**
Registrar's No. **102**

Registration District No. **47** Primary Registration District No. **3608**

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

4
1
2

1. PLACE OF DEATH:

(a) County **Calloway**

(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **State Hospital no. 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **26 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Boon**

(c) City or town **Columbia**
(If outside city or town limits, write "RURAL")

(d) Street No. **2**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM EDWIN THOMPSON**

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 **married**

6. (b) Name of husband or wife **Anna Elizabeth Thompson** 6. (c) Age of husband or wife if alive **57 1/2** years

7. Birth date of deceased **April 19 1868**
(Month) (Day) (Year)

8. AGE: Years **78** Months **10** Days **25** If less than one day hr. _____ min. _____

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **John Samuel Thompson**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Persinger**

15. Birthplace **Boon County Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Roads State Hospital no. 1**

(b) Address **Fulton Mo**

17. (a) **burial** (b) Date thereof **Mar 14 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Mo**

18. (a) Signature of funeral director **Walter J. ...**

(b) Address **Columbia Mo**

19. (a) **Mar 14 - 1947** (b) **Jose Morosukhoff**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14** year **1947** hour **4** minute **30 P.**M.

21. I hereby certify that I attended the deceased from **12 1/2** **18**, 19**47**, to **March 14**, 19**47**;
that I last saw him alive on **March 14**, 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia**

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 **J. R. ...** (M.D. or other) **M.D.**

Address **Fulton Mo** Date **3/14/47**

APR 18 1947

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3-18-47

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 *Charles D. Davis*

Licensed Embalmer No. *4132*

P. O. Address. *Columbia, 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.