

FILED MAY 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16467

Registration District No. 30

Primary Registration District No. 5102

Registrar's No. 20

1. PLACE OF DEATH:

(a) County: BENTON  
(b) City or town: FRISTOE RURAL Fristoe  
(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: wife  
years, months or days

3. (a) PRINT FULL NAME: MARY ROSE 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: WIDOWED

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

7. Birth date of deceased: MARCH 1 1961  
(Month) (Day) (Year)

8. AGE: Years: 86 Months: 2 Days: 11 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: BENTON COUNTY MO  
(City, town, or county) (State or foreign country)

10. Usual occupation: HOUSEWIFE

11. Industry or business: HOME

MOTHER FATHER { 12. Name: WILLIAM SHALL

13. Birthplace: MO  
(City, town, or county) (State or foreign country)

14. Maiden name: KATHLEEN SWANN

15. Birthplace: KY  
(City, town, or county) (State or foreign country)

16. (a) Informant: AMOS WOLFE

(b) Address: FRISTOE

17. (a) BURIAL (b) Date thereof: MAY 14, 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: NEW HOME

18. (a) Signature of funeral director: Reser FUNERAL HOME

(b) Address: WARSAW

19. (a) MAY 18/47 (b) Jas. A. Logan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: BENTON  
(c) City or town: FRISTOE RT I  
(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: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: MAY day: 12  
year: 1947 hour: 1 minute: 45 P.M.

21. I hereby certify that I attended the deceased from May 12, 1947 to May 12, 1947  
that I last saw her alive on May 12, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration: 3 hrs.

Due to: arterosclerosis unknown

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)  
(e) Means of injury: 2

23. Signature: [Signature] (a) or other: D.O.  
Address: Warsaw, Mo. Date signed: 5/13/47

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

Date Filed  
District File Number 5-27-47  
District Health Officer No. 71  
4-47-633  
RECEIVED

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.....

*John F. Reser*  
Licensed Embalmer No. 4098

P. O. Address.....

*Warsaw*

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.