

No. 2
12-45
5-17-39
X47070

FILED AUG 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23455**
Registrar's No. **920**

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Willard Hotel 216 1/2 N. 6th St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Not (Specify whether years, months or days)

In this community 50 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. Willard Hotel 216 1/2 N. 6th St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Byrl Thompson

3. (b) If veteran, name war None

3. (c) Social Security No. 497-12-2990

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month August day 1st year 1947 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 1 1947 to _____ 19____

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased: May 2 1890
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>2</u>	<u>29</u>	_____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Page County Iowa
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation Hog Buyer

11. Industry or business Stock Yards Co.

12. Name William H. Thompson

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

14. Maiden name Florence Nixon

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

16. (a) Informant Mrs. Froy Huddleston

(b) Address Kansas City, Missouri.

17. (a) Burial (b) Date thereof Aug. 4, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Halter Meierhoff

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 8-7-47 (b) Lo L Jenkins
(Date received local registrar) (Registrar's signature)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 Coroner

23. Signature B. W. Tadlock (M. D. or other) _____

Address King Hill Bldg. St. Joseph, Mo. Date signed 8/12/47

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

MOTHER FATHER

11
1
7
0

83A

3

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..... *Albert R. Harrington*

Licensed Embalmer No..... *3258 Missouri*

P. O. Address..... *St. Joseph, 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.