

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1948
128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
2000

State File No. 41434
Registrar's No. 1142

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH: GREENE
(a) County... Greene
(b) City or town... Springfield
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 12 days
In this community... 12 days
Specify whether years, months or days

3. (a) PRINT FULL NAME Carolyn Rae Thomas
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female
5. Color or race w
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 12 - 19 - 47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - 12 days hr. min.

9. Birthplace Springfield, Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Infant
11. Industry or business

MOTHER FATHER
12. Name Donald J. Thomas
13. Birthplace Paulding, Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Estella Eva Margaret
15. Birthplace Albion, Mich.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dan J. Thomas
(b) Address 2337 N. Missouri
17. (a) Burial (b) Date thereof 1/2/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 12-48 (b) M. Handly
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 37
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. St. John's Hospital 6
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country...

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 31
year 1947 hour 8 minute 10 A.M.
21. I hereby certify that I attended the deceased from Nov. 19
1947 to Nov 31, 1947
that I last saw her alive on Dec 31, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Immaturity
Duration

Due to...
Due to...
Other conditions:
(Include pregnancy within 3 months of death)
159

Major findings:
Of operations...
Of autopsy... None
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 6 ✓

23. Signature (M. D. or other)
Address Springfield, Mo. Date signed Dec 31, 1947

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.

This body was not embalmed.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.