

No. 300
10-47
5-17-39
SI 3906

FILED OCT 16 1948
Registration District No. **198**

Primary Registration District No. **4080**

Registrar's No. **19**

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

1. PLACE OF DEATH:
 (a) County Carroll
 (b) City or town Norborne Mo Egypt
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
241 North Greely Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
(Specify whether)
 In this community Life Time
years, months or days

3: (a) PRINT FULL NAME John Wesley Thompson
3. (b) If veteran, No **3. (c) Social Security No.** No
 name war

4. Sex Male **5. Color of race** Black
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jamuel Thompson **6. (c) Age of husband or wife if alive** 80 years
7. Birth date of deceased January 1 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>8</u>	<u>27</u>	hr. min.

9. Birthplace Carroll County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation labor until age

11. Industry or business Egypt to rail man

12. Name John Wesley Thompson

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

14. Maiden name Charlott Clark

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

16. (a) Informant Rosa M. Cannon

(b) Address 2435 2nd St

17. (a) Burial Funeral **(b) Date thereof** 8-31-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stemple Cemetery

18. (a) Signature of funeral director John Dutch

(b) Address Norborne Mo

19. (a) 8-30-48 **(b) Eileen Pennington**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Carroll
 (c) City or town Norborne
(If outside city or town limits, write "RURAL")
 (d) Street No. 241 North Greely Street
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug - day 27
 year 1948 hour 13 minute A M.

21. I hereby certify that I attended the deceased from Aug 26
 _____, 1948 to Aug 27, 1948
 that I last saw him alive on Aug 27, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
 Duration 1 day

Due to Cerebral Hemorrhage

Due to _____

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

Major findings: Of operations gob

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 0

23. Signature B. C. Cole (M. D. or other)

Address Norborne Mo Date signed 8-28-48

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 10-15-48

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed John G. Ditch

Licensed Embalmer No. 3654

P. O. Address Norborne 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.

Registration District No. 58 Primary Registration District No. 4080

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town hobson
(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)

3. (a) PRINT FULL NAME John W. Thompson
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex m **5. Color or race** B
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jannie Thompson **6. (c) Age of husband or wife if alive** 85
Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 80 Months 8 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ **(b) Date thereof** _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) 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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1947 Hour _____ minute _____ M. 27
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. In immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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** _____

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

SUPPLEMENTARY

S-32273