

FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11310**

BIRTH NO. _____		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 6225		Registrar's No. 59					
1. PLACE OF DEATH a. COUNTY Cernon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene							
b. CITY (If outside corporate limits, write RURAL and give township) Cross/Kennett Mo		c. LENGTH OF STAY (In the place) 4-78		c. CITY (If outside corporate limits, write RURAL and give township) Springfield		3-2-49					
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #3				d. STREET ADDRESS (If rural, give location) 827 South Kimbrough							
3. NAME OF DECEASED (Type or Print) SARAH A. THOMPSON			a. (First)		b. (Middle)		c. (Last)				
4. DATE OF DEATH March 19 1949		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 2-4-1869			
9. AGE (In years last birthday) 80		10. UNDER 1 YEAR Months 1 Days 16		11. BIRTHPLACE (State or foreign country) Adelaid Co Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. F UNDER 2 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Adelaid Co Ohio			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME D. W. Willis			13b. MOTHER'S MAIDEN NAME Sarah A. Turkey			14. NAME OF HUSBAND OR WIFE Widow					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give exact dates of service) No			16. SOCIAL SECURITY NO. ✓			17. INFORMANT'S SIGNATURE OR NAME Hospital records, Nevada			ADDRESS		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Typhoid Labor Acute				INTERVAL BETWEEN ONSET AND DEATH			
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile Deterioration							
				DUE TO (c) 490X							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension											
19a. DATE OF OPERATION none			19b. MAJOR FINDINGS OF OPERATION none						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 10-27, 1948 , to 3-19 , 1949, that I last saw the deceased alive on 3-19 , 1949, and that death occurred at 3-25 p.m., from the causes and on the date stated above.											
23a. SIGNATURE R. G. Hall M.D.				23b. ADDRESS Nevada Mo				23c. DATE SIGNED 3-19-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 20, 1949		24c. NAME OF CEMETERY OR CREMATORY Savannah, Ohio		24d. LOCATION (City, town, or county) (State) Savannah Ohio					
DATE REC'D BY LOCAL REG. Mar. 22-49		REGISTRAR'S SIGNATURE Kathryn H. Yancys		331		25. FUNERAL DIRECTOR'S SIGNATURE Alma Lohmeyer		ADDRESS Funeral Home, Springfield, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

10800

No. 300

10.48

RECEIVED
District Health Officer No. 7;
District File Number 2-49-296
Date Filed 3-29-49

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed Jewell E. Muehl

Licensed Embalmer No. 2831

P. O. Address Springfield

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.