S. No. 300
v. 10.48

FILED OCT 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34012

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4397

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital No. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 623 Euclid

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Ballard
c. (Last): Thompson

4. DATE OF DEATH (Month) 10 (Day) 11 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 6-1870
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR Months ~~3~~ Days ~~5~~ — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? US.
13a. FATHER'S NAME: Anderson Thompson
13b. MOTHER'S MAIDEN NAME: Sarah Watson
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NO
17. INFORMANT'S SIGNATURE OR NAME: Alice McKarnin — ADDRESS: Kansas City Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 27, 1949, *to* Oct. 11, 1949, *that I last saw the deceased alive on* Oct. 11, 1949, *and that death occurred at* 11:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm. W. Hart (Degree or title) — Wm. W. Hart M.D.
23b. ADDRESS: Med. Dir. Gen'l Hosp.
23c. DATE SIGNED: 10-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Oct 12-49
24c. NAME OF CEMETERY OR CREMATORY: Nebo Hill
24d. LOCATION (City, town, or county) (State): Clay Co. Missouri

DATE REC'D BY LOCAL REG.: 10-14-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Church-Archer Co. — ADDRESS: Liberty Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed John Sorberg

Licensed Embalmer No. 4448

P. O. Address Liberty 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.