

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40852

State File No. ....

BIRTH NO. .... REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1133

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>SPRINGFIELD</u>	c. LENGTH OF STAY (in this place) <input checked="" type="checkbox"/>	c. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD RURAL N. CAMPBELL</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>SPGFD. BAPTIST HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>2801 N. SUMMITT</u>	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) <u>ROSALIE</u>	b. (Middle)	c. (Last) <u>THOMAS</u>	(Month) (Day) (Year) <u>DEC. 20 1949</u>

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>20 DEC. 1873</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 SEES. Hours Mts.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>IN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>J.T. KELSO</u>	13b. MOTHER'S MAIDEN NAME <u>MARGARET LILMORE</u>	14. NAME OF HUSBAND OR WIFE <u>WILLIAM C. THOMAS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ROY JONES</u>	ADDRESS <u>SPEED MO.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis, generalized</u>		<u>11 days</u>
	ANTECEDENT CAUSES Adorbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ruptured Gall Bladder</u> DUE TO (c) <u>?</u>		<u>11 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>586X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from 12-9-, 1949, to 12-20-, 1949, that I last saw the deceased alive on 12-12-, 1949, and that death occurred at 3:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. W. Tillman Jr. M.D.</u>	23b. ADDRESS <u>Springfield</u>	23c. DATE SIGNED <u>12-20-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12-23-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>NEAR ASH GROVE, MO</u>
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DATE REC'D BY LOCAL REG. <u>12-22-49</u>	REGISTRAR'S SIGNATURE <u>W. H. Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Klingner &amp; Co.</u>	ADDRESS <u>Spfld. Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 8 1950

**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.

Signed \_\_\_\_\_

*Max Rhodes*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*40710  
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.