

FILED AUG 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24193

State File No.

BIRTH NO. _____ REG. DIST. NO. 264 PRIMARY REG. DIST. NO. 5898 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Frank</u>		2. USUAL RESIDENCE (Where deceased lived at institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Frank</u>	
b. CITY OR TOWN <u>Dora</u> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <u>Dora</u> (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS <u>R. F. D.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Flety</u> b. (Middle) <u>Thompson</u> c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>6-12-50</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>11-20-1867</u>
9. AGE (In years last birthday) <u>82</u>		10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) <u>Dora, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>R. Dadds</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Wheat</u>	
14. NAME OF HUSBAND OR WIFE <u>C. C. Thompson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Flety Thompson, Dora Mo</u> 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES _____ DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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 <u>3-25</u> , 19 <u>49</u> , to <u>6-12</u> , 19 <u>50</u> that I last saw the deceased alive on <u>6-9</u> , 19 <u>50</u> , and that death occurred at <u>1049 W. West Plains</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>C. Callahan</u> (Print or Title)		23b. ADDRESS <u>West Plains</u>	
23c. DATE SIGNED <u>6/23/50</u>		24a. BURIAL, CREMATION, DISPOSAL (Specify) _____	
24b. DATE <u>9-13-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Dora, Mo</u>	
24d. LOCATION (City, town or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cogswell</u> ADDRESS <u>405</u>	
DATE REC'D BY LOCAL REG. <u>7-24-50</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Lane</u> ADDRESS <u>West Plains Mo</u>	

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

~~DIVISION OF HEALTH OF MO.
District No. 5 - Springfield~~

~~RECEIVED JUL 19 1950~~

~~Dist. File 750-803~~

~~Date Filed 7-21-50~~

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED JUL 25 1950

Dist. File 730-877

Date Filed 7-31-50

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 _____

Licensed Embalmer No. 3437

P. O. Address West Plains

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.