

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5093

State File No.

FILED MAR 15 1954

755

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>755</u>			
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this country) <u>32 yrs</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>800 NORTH TOPPING AVENUE</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>LEE</u> b. (Middle) <u>ROY</u> c. (Last) <u>THOMPSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 15. 1954</u>						
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 26. 1899</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>KANSAS CITY SOUTHERN R.R.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>LEIYOX IOWA 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>CHESTER THOMPSON</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>MRS HAZEL THOMPSON</u>			
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>707 108933</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Genevieve Schoepflin 1316 E. 49th. K.C. MO.</u>					
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>Uremia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO <u>Compensative Heart Failure 7 Days</u> DUE TO <u>Myocardial Damage</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4222</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		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 <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>2-15, 1954</u> , to <u>2-15, 1954</u> , that I last saw the deceased alive on <u>2-15, 1954</u> , and that death occurred at <u>10:25 AM.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>W. P. Miller M.D.</u>					23b. ADDRESS <u>700 Ogden Bldg</u>			23c. DATE SIGNED <u>2-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>2-17-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>				
DATE REC'D BY LOCAL REG <u>2-17-54</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>O.H. Newcomer Sons 1331 - SOUTH CREEK KANSAS CITY, MO.</u>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
W. P. Miller

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.....
Signature of Student Embalmer

Signed.....
Rollie Kessel

Licensed Embalmer No. 469

P. O. Address.....
K C Y

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.