No. 300
10.48

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FILED APR 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8062

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 5562 Registrar's No. 24

1. PLACE OF DEATH
a. COUNTY: Iron
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pilot Knob
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):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri ~~Iron~~ COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pilot Knob 0470
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle): MATTHEW
c. (Last): THOMLINSON

4. DATE OF DEATH (Month) (Day) (Year): Mar. 27 1955

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 2 1874
9. AGE (In years last birthday): 81 — If under 1 year: Months 8 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 (retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iron County Missouri.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John Thomlinson
13b. MOTHER'S MAIDEN NAME: Mary M. Schrum
14. NAME OF HUSBAND OR WIFE: Lula Belle Thomlinson

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.:
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Roy Thomlinson, Arcadia 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) Acute Bilateral Pneumonia — 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)

DUE TO (c)

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: 493X
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 _____ 19___, to _____, 19___, that I last saw the deceased alive on _____ 1955, and that death occurred at 9:30 a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. H. Farrell Coroner
23b. ADDRESS: Ironton Mo
23c. DATE SIGNED: 3-30-55

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 3-31-55
24c. NAME OF CEMETERY OR CREMATORY: Fitzgerald Cemetery
24d. LOCATION (City, town, or county) (State): Middlebrook Mo.

DATE REC'D BY LOCAL REG.: 4-1-55
REGISTRAR'S SIGNATURE: Mrs Avis Jones
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: White Funeral Home, Ironton 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 Arnold J. White

Licensed Embalmer No. 2012

P. O. Address Taylor Tex

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.