

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 22 1957

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5512 Registrar's No. 42

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>Rural Prairie</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u> <u>7005</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>112 09 E. 40th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jackson County Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Vinnie</u> b. (Middle) _____ c. (Last) <u>Thompson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 11-1957</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, 1 WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 29-1883</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hour Min.
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</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>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jackson Co. Hospital Indpa Mo.</u> ADDRESS
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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>Myocardial Infarction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arterio Sclerotic Heart disease</u>		
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? <u>2</u> YES <input type="checkbox"/> NO <input checked="" 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) (m.)	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 Mar. 7, 1957, to Mar. 11, 1957, that I last saw the deceased alive on Mar. 10, 1957, and that death occurred at 3:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul Unknown MD</u>	23b. ADDRESS <u>Saline County Hosp</u>	23c. DATE SIGNED <u>3/11/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-13-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-12-1957</u>	REGISTRAR'S SIGNATURE <u>N. B. Langford</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Muehlebeck Funeral Home, Mo</u> ADDRESS <u>K.C.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

483

MAR 20 1957

RECEIVED

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

Thomas A. Koehler

Licensed Embalmer No. _____

4995

P. O. Address _____

A. O., MD

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.