

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**12237**

STATE FILE NUMBER

**FILED APR 29 1957**

42

1000

455

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Buchanan</b>		a. STATE <b>Missouri</b>	b. COUNTY <b>Buchanan</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph,</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital 40 yrs</b>		d. STREET ADDRESS <b>Rt #6</b> (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>		
First <b>Harry</b>			Month <b>April</b>		
Middle <b>Thompson</b>			Day <b>20,</b>		
Last <b>Thompson</b>			Year <b>1957</b>		
<b>5. SEX</b> <b>Male</b> <input type="checkbox"/>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 24, 1886</b>	<b>9. AGE (In years last birthday)</b> <b>70</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Ottumwa, Iowa</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>487-05-1387</b>	<b>17. INFORMANT</b> <b>Cora Thompson</b> Address <b>St. Joseph, Mo</b>		

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>
					<b>STATE</b>

<b>21. I attended the deceased from</b> <b>4/8/57</b> to <b>4/20/57</b> and last saw <del>her</del> <b>him</b> alive on <b>4/19/57</b> Death occurred at <b>12:30 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> <i>Quentin M. Blawie M.D.</i>	(Degree or title)	<b>22b. ADDRESS</b> <b>Social Welfare Board, 10th &amp; Olive, Patee Hall St. Joseph, Missouri</b>	<b>22c. DATE SIGNED</b> <b>4/21/57</b>

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>4/22/57</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bethel Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St. DeKalb, Mo</b>	(State)
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<b>24. FUNERAL DIRECTOR</b> <b>John P. Papp</b>	ADDRESS <b>St. Joseph, Mo</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>April 26, 1957</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Esther M. Allison</i>
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(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
Service

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USING ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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, ~~on~~ ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 398

P. O. Address..... St. Joseph

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.