

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028953
STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 66

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Armstrong 0450 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gee Hospital		Length of stay in 1b 1 week	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First NARCISSA Middle FOSTER Last THOMPSON			4. DATE OF DEATH Month Aug. Day 9, Year 1958	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1875	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Howard County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George Harvey	13b. MOTHER'S MAIDEN NAME Narcissa Snoddy	14. NAME OF HUSBAND OR WIFE Walter Scott Thompson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) (If yes, give year or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT Walter F. Thompson Address 451 Woodland Moberly, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 9 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Myocarditis		4 yrs
	DUE TO (c) + Cardiac De-compensation		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour ----- Month ----- Day ----- Year ----- a.m. ----- p.m. -----	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION ----- COUNTY ----- STATE -----
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21. I attended the deceased from Aug 5-58 to Aug 9 1958 and last saw her alive on Aug 9-58 Death occurred at ----- on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Walter F. Thompson (Degree or title)	22b. ADDRESS Fayette Mo	22c. DATE SIGNED 8-21-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/11/1958	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) Fayette, Missouri
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24. FUNERAL DIRECTOR Ralph A. Orr ADDRESS Fayette, Mo.	25. DATE RECD. BY LOCAL REG. 8/21/58	26. REGISTRAR'S SIGNATURE Mary K. Shell
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Student
Signature of Student Embalmer

Signed *Ralph A. Cass*

Licensed Embalmer No. *3340*

P. O. Address *Gayette, Mo.*

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.