

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038607
STATE FILE NUMBER

FILED OCT 27 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		c. CITY OR TOWN Milan	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b 12 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca Catherine Thompson			4. DATE OF DEATH Month Day Year 10 19 -58
5. SEX Fw	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1858
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sampsel Mo
13a. FATHER'S NAME Robert D. Duckworth		13b. MOTHER'S MAIDEN NAME Mary Jane Gann	14. NAME OF HUSBAND OR WIFE Melvin W. Thompson - dead
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Oscar Thompson - Milan Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>aden in chronic sinusitis</u> DUE TO (c) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH 3 hr 40 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 Milan, Sullivan Mo
21. I attended the deceased from <u>July 1955</u> to <u>at 7, 1958</u> and last saw her alive on <u>Oct 17, 1958</u> Death occurred at <u>11:30 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph H. Hughes M.D.</u>		22b. ADDRESS <u>Milan, Mo</u>	
22c. DATE SIGNED <u>10/24/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/21/58	23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	23d. LOCATION (City, town, or country) (State) Jamesport Mo.
24. FUNERAL DIRECTOR ADDRESS <u>Schoenes Dwight Schoenes Milan Mo</u>		25. DATE RECD. BY LOCAL REG. 10-22-58	26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

450

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 *Dwight Schoene*

Licensed Embalmer No. *2667*

P. O. Address *Milan - Ill.*

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.