

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032171

FILED VS SEP 28 1959

Registration District No. 141 Primary Registration District No. 5554 Registrar's No. 125 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ozark</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Davis Creek RT.</u>		Length of stay in 1b <u>6 months</u>		c. CITY OR TOWN <u>Tecumseh</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Spring Creek twp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R.</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>59</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-23-1891</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and state or country) <u>Ozark Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>David Thompson</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>Ellen Small Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Homer Thompson</u> Address <u>Tecumseh Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>							<u>5 m1</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)		DUE TO (b) <u>Coronary thrombosis</u>					<u>2 hr</u>	
		DUE TO (c) <u>Arteriosclerosis</u>					<u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <u> </u> a.m. <u> </u> p.m.		Month, Day, Year						
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	
21. I attended the deceased from <u>3-11-49</u> to <u>8-29-59</u> and last saw him alive on <u>7-14-59</u> Death occurred at <u>5:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>E. Callahan</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>West Plains, Missouri</u>			22c. DATE SIGNED <u>9-3-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clear Springs</u>		23d. LOCATION (City, town, or county) <u>Ozark Co. Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Cliff Kingboard</u> ADDRESS <u>Gainesville</u>			25. DATE RECD. BY LOCAL REG. <u>9-21-59</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Urney

Licensed Embalmer No. 4885

P. O. Address Camden

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.