

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS. JAN - 6 1960 200

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Macon b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Macon Length of stay in 1b _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Samaritan Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon c. CITY OR TOWN Macon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 411 Jackson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First THOMAS (Tom) Middle Thomas Last Thomas	4. DATE OF DEATH Month Dec. Day 19 Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-11-1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (City and state or country) Macon Co. Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Thomas	13b. MOTHER'S MAIDEN NAME Margret Howell	14. NAME OF HUSBAND OR WIFE Meta Barr Thomas
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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) No	16. SOCIAL SECURITY NO. 494-38-3392	17. INFORMANT Address Mrs. Meta Thomas Macon, 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) <i>Probably Coronary Occlusion</i> DUE TO (b) <i>Chronic Myocarditis & Valvular disease</i> DUE TO (c) <i>Chronic Kidney insufficiency</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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	INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>years</i> <i>years</i>
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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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
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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 *Dec 15, 1959* to *19 Dec 59* and last saw him alive on *19 Dec 59*
 Death occurred at *8:00 AM 19 Dec 59* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Donald E Eggleston MD</i>	22b. ADDRESS <i>Macon, Missouri</i>	22c. DATE SIGNED <i>21 Dec 59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/21/1959	23c. NAME OF CEMETERY OR CREMATORY Oakwood	23d. LOCATION (City, town, or county) (State) Macon Missouri
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24. FUNERAL DIRECTOR <i>Walter Brun</i>	ADDRESS Macon, Mo.	25. DATE RECD. BY LOCAL REG. 12/30/59	26. REGISTRAR'S SIGNATURE <i>Paul Muehly</i>
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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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

R. Lester Brown

Licensed Embalmer No. 4472

P. O. Address Mason, N.J.

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.