

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010418

FILED VS APR 6 1960

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 34 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Dent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Salem</b>		Length of stay in 1b <b>33 yrs</b>	c. CITY OR TOWN <b>Salem</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>at home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Park Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Winfred</b> Middle <b>H.</b> Last <b>Thompson</b>	4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1960</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 30-19 41</b>	9. AGE (last birthday) <b>41</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>factory employe</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>She Mfg. Co</b>	11. BIRTHPLACE (City and state or country) <b>Shannon County Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Vint Thompson</b>	13b. MOTHER'S MAIDEN NAME <b>Ruth Carver</b>	14. NAME OF HUSBAND OR WIFE <b>Dorothy Majors</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>495 14 2728</b>	17. INFORMANT <b>Dorothy Thompson Salem Mo</b> Address
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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) <b>Coronary thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</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)	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
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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 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 <b>Aug 2, 1954</b> to <b>April 4, 1960</b> and last saw <sup>her</sup> him alive on <b>March 14, 1960</b> Death occurred at <b>5 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Ray Mitchell, M.D.</i>	22b. ADDRESS <b>Salem, Missouri</b>	22c. DATE SIGNED <b>4-5-60</b>
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23a. BURIAL OR CREMATION REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4-5-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Salem Mo</b>
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24. FUNERAL DIRECTOR <b>Spencer Funeral Home Inc</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4/5/60</b>	26. REGISTRAR'S SIGNATURE <i>M.M. Hart, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 24 1960

STATEMENT BY LICENSED EMBALMER

APR 18 1960

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 Carl H. Spence

Licensed Embalmer No. 9371

P. O. Address Submitt

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.