

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-030374

FILED VS AUG 22 1960

Registration District No. 141 Primary Registration District No. 3029 Registrar's No. 120

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Howell</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Howell</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>West Plains, Mo.</i>		Length of stay in 1b <i>days</i>		c. CITY OR TOWN <i>Siloam Springs, Mo.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <i>Memorial Hospital</i> INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>Twin Bridges Rte.</i>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Macklin</i> Last <i>Thompson</i>				4. DATE OF DEATH Month <i>7</i> Day <i>24</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>whi.</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>12-30-1893</i>	9. AGE (last birthday) <i>66yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>X X X</i>		11. BIRTHPLACE (City and state or country) <i>Richville, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>E. B. Thompson</i>			13b. MOTHER'S MAIDEN NAME <i>Minnie Maess</i>		14. NAME OF HUSBAND OR WIFE <i>Lulella Stecker</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes W. W. I.</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Mrs. C. M. Thompson, Siloam Sprgs, Mo</i>			
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>Myocardial Infarction</i> DUE TO (b) <i>Arteriosclerosis/Heart Disease 10 years</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized Arteriosclerosis</i>				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 _____ 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 _____
21. I attended the deceased from <i>April 26, 1958</i> and last saw him alive on <i>7-24-60</i> Death occurred at <i>2:00 a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.				_____			
22a. SIGNATURE <i>Jack N. Wiles, M.D.</i>			22b. ADDRESS <i>West Plains, Mo.</i>		22c. DATE SIGNED <i>8-9-60</i>		
23a. BURIAL CREMATION, REBURY (Specify) <i>B</i>	23b. DATE <i>7-26-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Howell Memorial Park Cem.</i>		23d. LOCATION (City, town, or county) <i>West Plains, Mo.</i>		(State) _____	
24. FUNERAL DIRECTOR "Robertson's" ADDRESS <i>West Plains, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>8-16-60</i>		26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 23 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *W. F. [Signature]*

Licensed Embalmer No. 454

P. O. Address West Plain

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.