

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-005087

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 324 Primary Registration District No. 693 Registrar's No. 20

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY Saline			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dunklin		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall		Length of stay in 1b 4 yrs.	c. CITY OR TOWN Holcomb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Marshall State School &		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) -----		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gary Middle Garland Last Thompson			4. DATE OF DEATH Month January Day 25 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1946	9. AGE (last birthday) 15 yrs. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patient		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Holcomb, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Arvel Allen Thompson		13b. MOTHER'S MAIDEN NAME Gail V. Northington		14. NAME OF HUSBAND OR WIFE Records of Marshall State School & Hosp., Marshall, Mo.	
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. None		17. INFORMANT School & Hosp., Marshall, 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) Influenza pneumonia					INTERVAL BETWEEN ONSET AND DEATH 48 hours
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) Mental retardation with athetoid ataxia and epilepsy				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 4-1-1959 to 1-25-62 and last saw her/him alive on 1-24-62 Death occurred at 2:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE A. B. Day, M.D.			22b. ADDRESS Marshall State School & Hospital, Marshall, Mo.		22c. DATE SIGNED 1-25-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-25-62	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR Harry Horshberger Marshall Mo		25. DATE RECD. BY LOCAL REG. 1-25-62		26. REGISTRARS SIGNATURE Cecil G. Reed	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FEB 8 1962

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.