

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012385

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 24

FILED APR 15 1963

VS 300
Rev. 4/59

1 0595

2 05952

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12 90-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY LIVINGSTON		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MO. b. COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in 1b 2 MONTHS	c. CITY OR TOWN CHILLICOTHE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRENTON ROAD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) TRENTON ROAD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD CAVE THOMPSON			4. DATE OF DEATH Month Day Year APRIL 8 1963
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 9/19/02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	9. AGE (last birthday) 60 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. FATHER'S NAME MARION THOMPSON		11b. MOTHER'S MAIDEN NAME IDA BARGAR	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. NAME OF HUSBAND OR WIFE CORINNE BEAIRD		14. SOCIAL SECURITY NO. 15 17. INFORMANT MRS. C.C. THOMPSON Address Chillicothe, Mo. Rt. #5	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of)		18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung. 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) Metastasis to lumbar spine		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 Chillicothe	COUNTY STATE
21. I attended the deceased from 11-7-62 to 4-7-63 and last saw ^{her} him alive on 4-7-63 . Death occurred at 1:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Donald M.S.		22b. ADDRESS Chillicothe Mo	22c. DATE SIGNED 4-8-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/10/63	23c. NAME OF CEMETERY OR CREMATORY MEADVILLE CEMETERY	23d. LOCATION (City, town, or county) MEADVILLE, MISSOURI
24. FUNERAL DIRECTOR NORMAN FUNERAL HOME: Chillicothe, Mo.		25. DATE RECD. BY LOCAL REG. April 9, 1963	26. REGISTRAR'S SIGNATURE Russell Taylor

USE BLACK INK OR TYPEWRITER RIBBON

MAY 2 1963

MAY 16 1963

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 Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MISSOURI

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.

DR. DON DOWELL