

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033069

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 231 Primary Registration District No. 4390 Registrar's No. 197

STATE FILE NUMBER

FILED AUG 26 1963

VS 300 Rev. 4/59	DATE AMENDED					
10740		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS				
20740						
3						
4 0						
5 3						
6						
7 1						
8 0						
9 422.1						
10						
11						
12 90.0						
13 10						

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ARKOE</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>ARKOE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARVY</u> Middle <u>LEE</u> Last <u>THOMPSON</u>			4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	9. AGE (last birthday) <u>87</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HR: Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Campbell Thompson</u>		13b. MOTHER'S MAIDEN NAME <u>Cuthia Gilbert</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		15. WAS RECEIVED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of date of service) <u>Yes - Spanish War -</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mrs. DONA MOWRY - ARKOE, Mo</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Decompensation</u> DUE TO (c) <u>Chronic Myocarditis + arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Since June 1962</u> <u>Several years</u>
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
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 <u>5 p.</u> Month, Day, Year <u>June 18, 1963</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT-WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Maryville Mo</u> COUNTY STATE	
21. I attended the deceased from <u>June 18, 1963</u> to <u>Aug 21, 1963</u> and last saw her alive on <u>June 22, 1963</u> Death occurred at <u>5 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W.R. Jackson, M.D.</u> (Degree or title)		22b. ADDRESS <u>Maryville Mo</u>	
22c. DATE SIGNED <u>8-22-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-24-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Miriam Fern - Maryville, Mo</u>		23d. LOCATION (City, town, or county) <u>Maryville, Mo</u>	
24. FUNERAL DIRECTOR <u>Hickson - Maryville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8 22 63</u>	
26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>			

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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

George M. Allison Jr.

Licensed Embalmer No.

5114

P. O. Address

Maryville, Mo

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.