

S. No. 2
M-5-43
5-17-39
X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16117**
Registrar's No. _____

FILED MAY 12 1947
Registration District No. **336**

Primary Registration District No. **6130**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County SHANNON

(b) City or town RURAL - TOWNSHIP #3
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 5 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SHANNON ¹⁰¹

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. TOWNSHIP #3
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CARRIE THOMPSON

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife J. D. THOMPSON

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased AUGUST 20 1889
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 5
year 1947 hour 2 minute 45 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>7</u>	<u>15</u>	— hr. — min.

Immediate cause of death Infarction of Myocardium Duration _____

Due to _____

Due to _____

9. Birthplace REYNOLDS COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN PRICE

13. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name LIZZIE WATSON

15. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant J. W. Thompson

(b) Address Round Springs, Mo.

17. (a) BURIAL (b) Date thereof APRIL 7, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation UNION HILL CEMETERY

18. (a) Signature of funeral director Hobson & Brantman

(b) Address Salem, Mo.

19. (a) 5-3-47 (b) Moore Raen
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature Frank Hyde (M. D. or other) _____
Address Quincy, Mo. Date signed 4-22-47

RECEIVED

District Health Officer No. 5,

District File No. 54-2275

Date Filed 5-10-47

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.....

Edward F. Brayles....., Registered Apprentice No. 435
working under my personal supervision.

Signed Max L. Waibel.....

Licensed Embalmer No. 4170

P. O. Address Salem, Ind.

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 this body is not embalmed, fact should be so stated above.