LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 22351

1 PLACE OF DEATH

County: Shelby

Township: Blackcreek
or
Village:
or
City: Shelbyville (NO. 6092 St.; Ward)

Registration District No. 831 File No.
Primary Registration District No. Registered No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas William Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June 19 (Month) (Day) 1916 (Year)

7 AGE: 5 yrs. 6 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Idiot
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Shelby Co. Mo

PARENTS

10 NAME OF FATHER: E. P. Thompson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Shelby Co.

12 MAIDEN NAME OF MOTHER: Emma Davidson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. M. Thompson
(Address): Shelbyville Mo

15 Filed Aug 10 1921 W. H. Carson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 10 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 28 1921, to Aug 10 1921, that I last saw him alive on Aug 9 1921, and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:
Diphtheria
10
(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) P. C. Crocker M. D.
Aug 10 1921 (Address) Shelbyville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Shelbyville I.O.O.F. DATE OF BURIAL: Aug 11 1921

20 UNDERTAKER: Hagi ADDRESS: Shelbina

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ...., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....,191....., to .....,191.....,
that I last saw h.....alive on .....,191.....,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
....., 191.....

20 UNDERTAKER

ADDRESS