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

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.

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

PLACE OF DEATH

County Nevada

Township Lafayette

or

Village

or

City (NO. Thompson St.; Ward)

Registration District No. ~~607~~ 602 File No. ~~27~~ 220216

Primary Registration District No. 0798 Registered No.

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

FULL NAME T A Thompson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE w

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

DATE OF BIRTH 61 y Can't Ascertain (Month) (Day) 1860 (Year)

AGE 63 yrs. mos. ds.

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

OCCUPATION (a) Trade, profession, or particular kind of work Pauper County

(b) General nature of industry, business, or establishment in which employed (or employer) Inmate Co. Farm

BIRTHPLACE (City or town, State or foreign country) Dent Knee

PARENTS

NAME OF FATHER Dent Knee

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

MAIDEN NAME OF MOTHER " "

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H Dalby

(ADDRESS) Portageville Mo

Filed 10/1 1923 ~~R. K. Miller~~ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7 (Month) 2 (Day) 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from —, 191, to —, 191, that I last saw h— alive on July 2, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

171

168 Commit Suicide stuck for Scissors in heart (Duration) yrs. mos. ds.

Contributory (SECONDARY) punctured heart

Install (Duration) yrs. mos. ds.

(Signed) H A Kerrian M. D.

7-2 1923 (Address) Portageville Mo

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

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

PLACE OF BURIAL OR REMOVAL Pauper Grave Yard.

DATE OF BURIAL 7/3 1923

UNDERTAKER R Dyoung Portageville Mo

ADDRESS

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

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]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

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

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____
(Month) (Day) (Year)

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.

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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

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

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.