

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

Do not use this space.

35262

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **Ev Route & City Corp #1**)

File No.....

Registered No. **10248**

St..... Ward

2. FULL NAME

Efrow Thompson

(a) Residence. No. **1015 N. 7th St.** Ward. **10**

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widower**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Unknown**

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
abt 64 | ✓ | ✓

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Carpenter**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Indiana**
(STATE OR COUNTRY)

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **UNKNOWN**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT **J. W. Kerner**
(Address) **Couriers Office**

15. FILED **10 1924** **Paul Starckoff**
REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 15 19 28**

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... **5:15 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
932

CONTRIBUTORY (SECONDARY) **W. M. G.**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

8. DID AN OPERATION PRECEDE DEATH DATE OF
WAS THERE AN AUTO

WHAT TEST CONFIRMED DIAGNOSIS:
(Signed) **J. W. Kerner, M.D.**
10/17/28 (Address) **City, Mo.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St Matthews** DATE OF BURIAL **10-19 1924**
ADDRESS **7318**

20. UNDERTAKER **Southern**
S. Brady

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.

