JAN 28 1929

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

Do not use this space.

43712

1. PLACE OF DEATH

County: Scottland — Registration District No.: 812

Township: Johnson — Primary Registration District No.: 6061

City: ..... (No. ..... St. ..... Ward)

File No.: .....

Registered No.: 3

2. FULL NAME: Alphus Spencer Thompson

(a) Residence. No. ..... St., ... Ward. .....
(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): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 1 1859

7. AGE — YEARS: 67 — MONTHS: — DAYS: 16 — IF LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

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

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): .....
(STATE OR COUNTRY): VanBurm Co Iowa

PARENTS

10. NAME OF FATHER: Nanie Thompson

11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Indaina

12. MAIDEN NAME OF MOTHER: Annie Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Indaina

14. INFORMANT: Mrs AlphusThompson
(Address): Cantril Iowa

15. FILED: 1/1, 19 29 — O. A. Baker — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 17 28 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 28, 19..., to Dec 16 28, 19..., that I last saw him alive on Dec 16 28, 19..., and that death occurred, on the date stated above, at 7 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardac - Decompensation

95 / 29 / 132 (duration) Several yr mos. ds.

CONTRIBUTORY (SECONDARY): Bright Deseare

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: —

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? NO — DATE OF .....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) N. Lee Miller, M. D.

12/18, 19 28 (Address) Cantril Iowa

*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: Parie View Cemerty — DATE OF BURIAL: Dec 19 19 28

20. UNDERTAKER: W.W. Wellborn — ADDRESS: Cantril

W

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

1. PLACE OF DEATH

County Scotland — Registration District No. 812 — File No. .....

Township Johnson — Primary Registration District No. 6061 — Registered No. 3

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Alphus Spencer Thompson

(a) Residence. No. ..... St., ... Ward. .....
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-1-1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
67		—	16	

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

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1/1, 1929 — P. H. Baker M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-430112