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

Do not use this space.

3141

1. PLACE OF DEATH
County: St Charles — Registration District No.: 757 — File No.:
Township: St Charles — Primary Registration District No.: 3036 — Registered No.: 3
City: St Charles (No. St Joseph Hospital St. 2 Ward)

2. FULL NAME: Mary Anna Ruth 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. 1 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 7 — 1927

7. AGE: Years 1 | Months 5 | Days 25 | If LESS than 1 day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN): Granger
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Arnold L Thompson
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Lincoln Co Mo
12. MAIDEN NAME OF MOTHER: Therern Wurzler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): St Charles Co Mo

14. INFORMANT: Arnold L Thompson
(Address): Hamburg, Mo

15. FILED: 1/3 1929 Ry. G. Bloebaum, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1928, to Jan 2 1929, that I last saw h. alive on Jan 1 1928, and that death occurred, on the date stated above, at 2:00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess brain
0013
0.13
782
0.17
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Oedema Brain
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF Nov 27, 1928
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Vincent A. Schneider, M. D
, 19 (Address) St. Charles, 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 Peters Cemetery — DATE OF BURIAL: Jan 3 — 1929

20. UNDERTAKER: Steinbruker Funeral Home — ADDRESS: St Charles Mo

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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Charles — Registration District No. 757 — File No. .....

Township ..... — Primary Registration District No. 3036 — Registered No. .....

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

2. FULL NAME Mary Ann R. 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S

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

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

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

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 1/3 1929 Hy. G. Bloebaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 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:

Abscess brain
Metastic from acute
mastoiditis

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

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

86B

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

...ATED EXACTLY. ...YSICIANS should state ...statement of OCCUPATION is very important.

...USE OF DEATH ... REGISTRARS SHALL NOT RECEIVE ... FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-3141