

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. Research Hospital)

Registration District No. 399  
Primary Registration District No. 3602

21579

File No. 2710  
Registered No. 2710  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Martin Thompson

(a) Residence No. 2018 Cypress St. 12 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 Mabel Thompson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1865

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|--------|------|--|
|        | 64    | 0      | 6    |  |

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work 124E 107A  
Hatchman  
(b) General nature of industry, business, or establishment in which employed (or employer) 118C  
Hotel Dept - C  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Penn

10. NAME OF FATHER William Thompson

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

12. MAIDEN NAME OF MOTHER Marcella Costello

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

14. INFORMANT May E. Veatch  
(Address) 623 E 8 St

15. FILED 6/18/29 M. M. Crowe  
REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1928, to June 16, 1929 that I last saw him alive on July 16, 1929, and that death occurred, on the date stated above, at 12:45 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

embolism (hepatic)

122 B1 (duration) 3-4 yrs. mos. ds.  
CONTRIBUTORY gastro-splanchnic  
(SECONDARY) hemorrhage + bronchopneumonia  
(duration) \_\_\_\_\_ yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Blooding - neg. X-Ray  
(Signed) Dr. J. J. Jones, M. D.

6/16, 1929 (Address) 400 W. 12th St

\*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

St. Marys' Cemetery 6/19/29 19

20. UNDERTAKER ADDRESS

Quirk & Tobin Co--20 W Linwood

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.

182  
180  
180

