

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

Do not use this space.

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File No. _____
Registered No. _____
St. _____ Ward _____

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PLACE OF DEATH
County Warren Registration District No. 283
Township Burgess Primary Registration District No. 5402
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Matilda Thomas
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-10-1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47 0 20

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) Illinois

10. NAME OF FATHER Ben Forbes

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

12. MAIDEN NAME OF MOTHER Bessie Martin

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

14. INFORMANT Jess Thomas
(Address) Codeville Mo

15. FILED 17/16 1929 E. Newson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-30 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov-20 1929 to Nov-30 1929 that I last saw h. alive on Nov-30 1929 and that death occurred, on the date stated above, at 4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
107A

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

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Elis Beach M. D.
. 19 (Address) Codeville 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 Codeville Cemetery DATE OF BURIAL 17-1st 1929

20. UNDERTAKER Howard Anderson ADDRESS Codeville Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Linn
Township Buffalo
City (No.)

Registration District No. 283
Primary Registration District No. 542

File No. 66
Registered No.
St. Ward

2. FULL NAME Matilda Thomas

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1929

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

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.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Professionia Bronche
(duration) yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) 100%
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

10. NAME OF FATHER

IF NOT AT PLACE OF DEATH

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

DID AN OPERATION PRECEDE DEATH? DATE OF

12. MAIDEN NAME OF MOTHER

WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) , M. D.
, 19 (Address)

14. INFORMANT
(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.

15. FILED 12-1 1929 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

SECRET

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