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

Do not use this space. 3844

FEB 20 1930

1. PLACE OF DEATH Vernon

County ..... Registration District No. 875 File No. .....

Township Washington Primary Registration District No. 6162 Registered No. 8

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

2. FULL NAME S. W. Thompson

(a) Residence. No. State Hospital #3 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. 24 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 Mrs. Hattie Thompson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19, 1888

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
41	7	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work mechanic (R.R.)

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Miss.
~~(STATE OR COUNTRY)~~ J.R. Thompson

PARENTS

10. NAME OF FATHER " " "

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not given
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not given

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

14. INFORMANT Mrs. Hattie Thompson
(Address) Springfield Mo.

15. FILED 2/5 1930 E.R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1930, to Jan. 26, 1930 that I last saw him alive on ....., 1930, and that death occurred, on the date stated above, at 8 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis
5.3A

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31

..... (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? Clinical

(Signed) T. T. O'Dell, M. D

Jan. 26, 1930 (Address) Nevada 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 Spgfld Mo

DATE OF BURIAL 1-27 1930

20. UNDERTAKER A. V. Hays

ADDRESS Nevada 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.

63 2 31

Cst.1 5.5
Emb .25
Telephone 1.50