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

11987

1. PLACE OF DEATH
County ..... Registration District No. 207 File No. 19
Township Concordia Primary Registration District No. 4125 Registered No. 58
City ..... (No. ..... St. ..... Ward)

2. FULL NAME John Benjamin 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 30 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 Eva K. Thompson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 4, 1862

7. AGE: Years 69 Months 6 Days 13 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) Clinton Co.
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Samuel Thompson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina
12. MAIDEN NAME OF MOTHER Elizabeth Hale
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs. Eva K. Thompson
(Address) Plattsburg Mo.

15. FILED April 1932 John Kg Sorrner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-17 1932

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1932, to April 17, 1932, that I last saw him alive on April 17, 1932, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Scirrhous Carcinoma head of pancreas (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) Cholemia (duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF (1)
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) W B Shaldrin, M. D
, 19 (Address) Plattsburg 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Plattsburg Mo
DATE OF BURIAL: 4-20 1932

20. UNDERTAKER: Nelson & O'Brien
ADDRESS: Plattsburg 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

1. PLACE OF DEATH

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

Township..... Primary Registration District No..... Registered No. .....

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

2. FULL NAME .....

(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. d

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

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).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICID HOMICIDAL. (See reverse side for additional space.)

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

20. UNDERTAKER | ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.