

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

Do not use this space.

MAY 25 1934

**1. PLACE OF DEATH**

County Lewis  
Township Highland  
City Fulton

Registration District No. 478  
Primary Registration District No. 3642

File No. 13454  
Registered No. 0  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Melba Nelson 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 13 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 MEDICAL CERTIFICATE OF DEATH**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William Thos. Ball</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 27, 1857</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>8</u>	DAYS <u>6</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housewife</u>		9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 23, 1934  
22. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1934 to April 22, 1934  
I last saw her alive on April 22, 1934. Death is said to have occurred on the date stated above, at 9 A. m.  
The principal cause of death and related causes of importance were as follows:

Tuberculosis (chronic)  
Ovarian Cyst  
Pleurisy

Date of onset  
1934

Other contributory causes of importance

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>
13. NAME <u>Lucile Stolzal</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>
15. MAIDEN NAME <u>Rand F. Peachon</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>
17. INFORMANT (ADDRESS) <u>Clara S. Smith</u> <u>Home</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Mt. Olive</u> DATE <u>April 24, 1934</u>
19. UNDERTAKER (ADDRESS) <u>Thos Ball</u> <u>Ewing Mo</u>
20. FILED <u>5/9</u> 19 <u>34</u> <u>Anna K. Bull</u> Registrar.

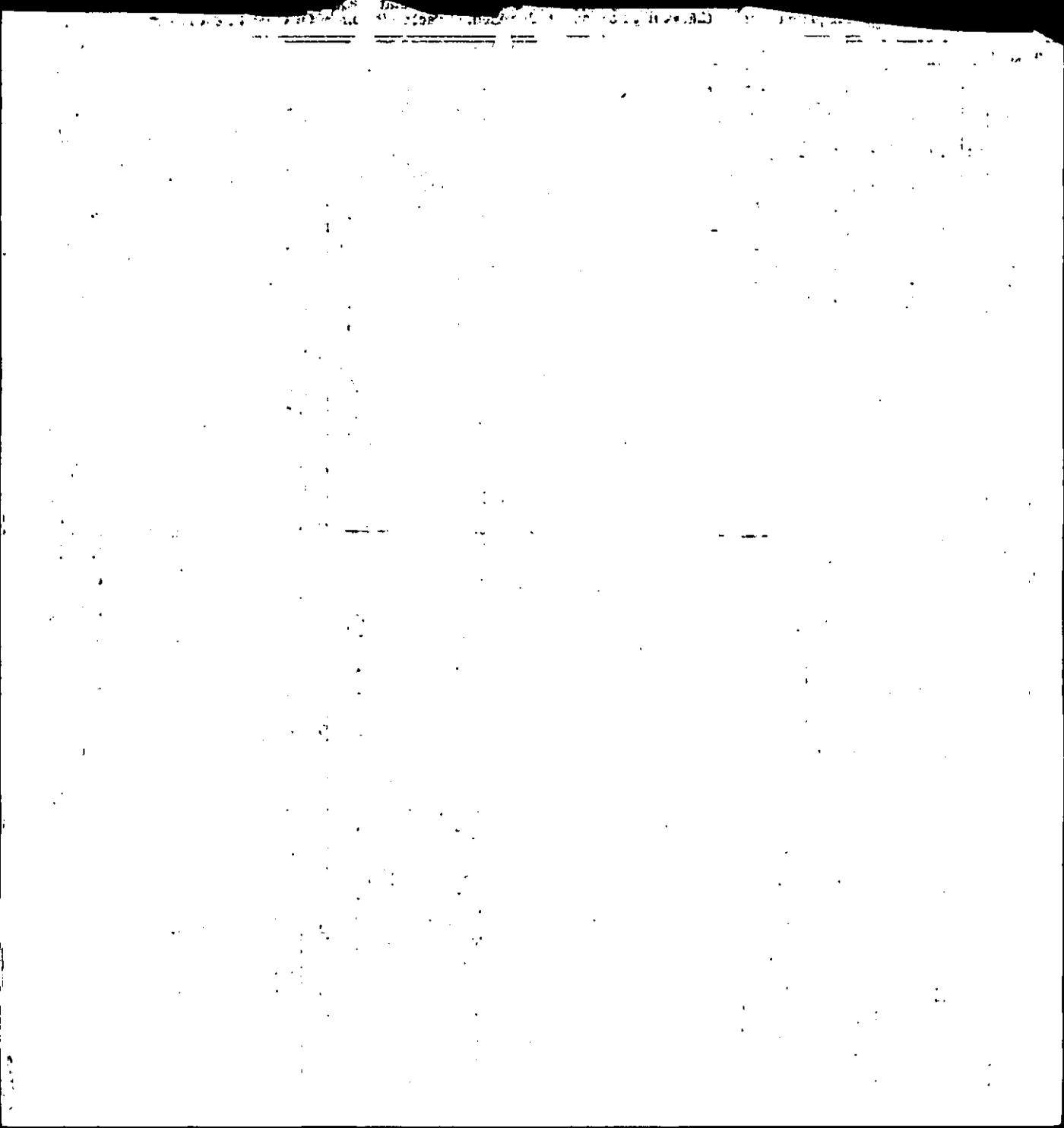
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) W. R. Ewing, M.D.  
(Address) Ewing Mo.

COPY OF DEATH CERTIFICATE TO BE FILED IN THE OFFICE OF THE CLERK OF THE COURT IN THE COUNTY OF LEWIS, MISSOURI, IN THE YEAR 1934.



**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 Lewis  
Township Highland  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 47.8  
Primary Registration District No. 2-642

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

Medora Nelson Thompson

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 27, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 8 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. H. M.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kennett, Mo.

13. NAME Jacob Stokely

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Putnam, Mo.

15. MAIDEN NAME Sarah F. Fisher

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wagoner, Mo.

17. INFORMANT (ADDRESS) Clara Stokely

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Olive DATE Apr 24, 1932

19. UNDERTAKER (ADDRESS) Thomas Ball

20. FILED 19 Anna K. Ball Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_, 19\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD, AS SUCH, SHOULD BE KEPT IN A SAFE PLACE. THE COPY SHOULD BE PRESERVED BY LAW.

TEMPORARY

S-13454

COMWEL

Please state whether deceased  
had Chronic Tuberculosis of the  
lung, or, whether this was  
a tuberculous cyst or ovary.

(52)-13454

Apr 23, 1934

#2  
*Lewis*

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
WASHINGTON

E. T. McGaugh, M. D.,  
Special Agent,  
Jefferson City, Mo.

*File no. 13454*

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Medara Nelson Thompson*  
Who died at \_\_\_\_\_ on *April 23 - 1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex \_\_\_\_\_ Color or race \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: *Tuberculosis (Chr) Osseous Cryst*  
*Pleuresy Tuberculosis of lung.*

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *478*

Primary Reg. Dist. No. *5642*

Very truly yours,  
*E. T. McGaugh M.D.*  
*S.C.*

Special Agent.

5431-13454