

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.

MAY 19 1936

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

Do not use this space.

15081

1. PLACE OF DEATH

County Jackson Registration District No. 399  
Township Wesley Primary Registration District No. 1002  
City Wesley Hosp (No. Wesley Hospital)

File No. \_\_\_\_\_  
Registered No. 1785  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. Liberty, Mo. #2 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)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the words) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lula Thomas</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct. 4 - 1879</u>		
7. AGE	YEARS <u>56</u>	MONTHS <u>5</u>
	DAYS <u>28</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>in Secy.</u>	
	10. Date deceased last worked at this occupation (month and year) <u>1/1</u>	
	11. Total time (years) spent in this occupation <u>30</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Liberty, Mo.</u>		
MOTHER	13. NAME <u>Rose Thomas</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky</u>	
	15. MAIDEN NAME <u>Barbara Greenwood</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky</u>	
17. INFORMANT (ADDRESS) <u>Mr. Lula Thomas, Liberty, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	<u>Liberty</u>	DATE <u>4/5/36</u>
19. UNDERTAKER (ADDRESS) <u>Church &amp; Co. 1200 N. Main</u>		
20. FILED <u>Apr 2 1936 m.m. Ordover</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 2 1936

22. I HEREBY CERTIFY, That I attended deceased from March 28, 1936, to March April 2, 1936. I last saw him alive on April 2, 1936. Death is said to have occurred on the date stated above, at 8 p.m.. The principal cause of death and related causes of importance were as follows:

Date of onset Feb 15

acute intestinal obstruction  
chronic miocarditis

Other contributory causes of importance:  
170 B

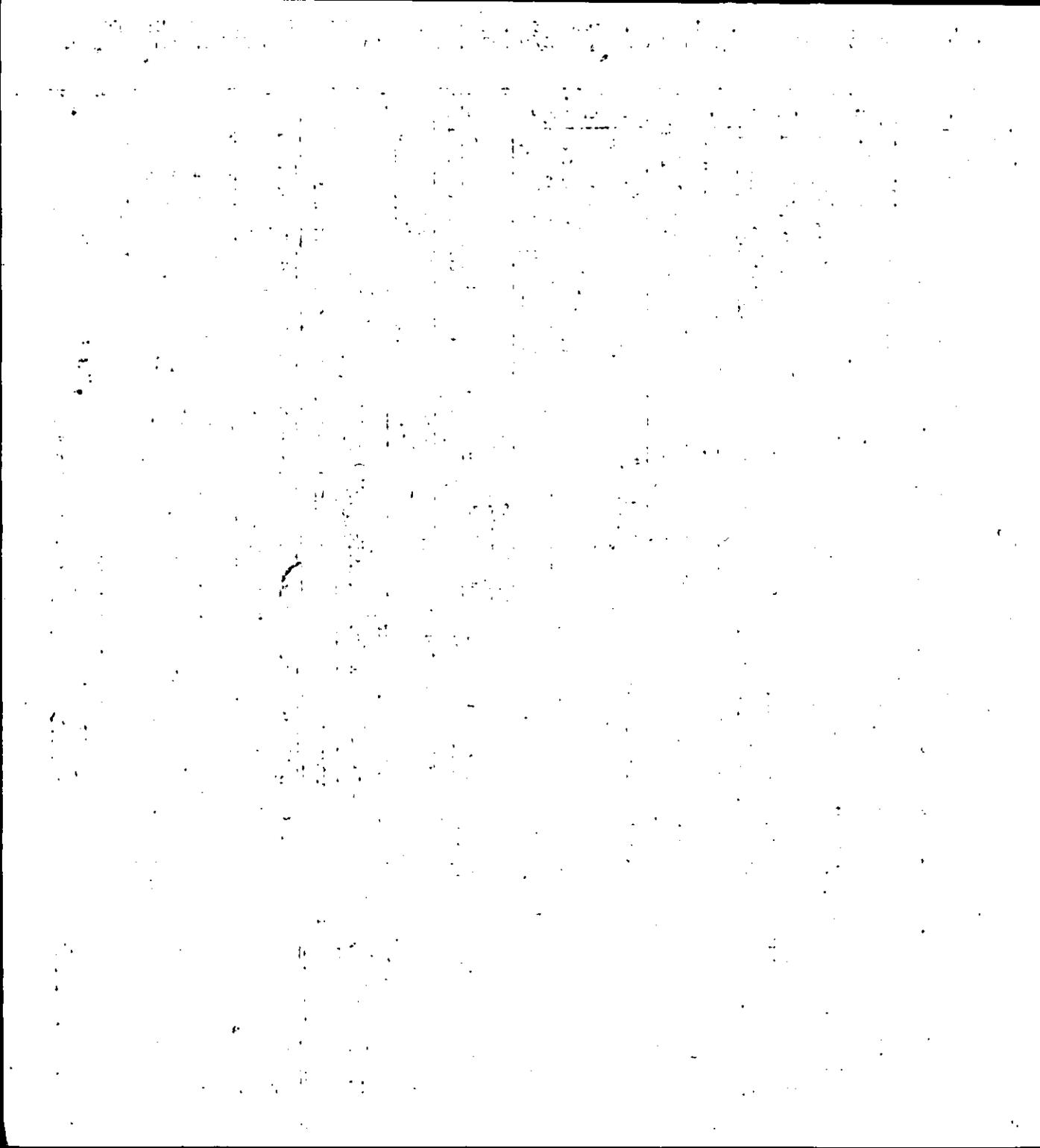
Name of operation Colostomy Date of 3/30/36  
What test confirmed diagnosis? operation Was there an autopsy? no

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) R. N. Scapp, M. D.  
(Address) 530 Prof. Building  
He mo

Registrar.



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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township K. C.  
City K. C. (No. \_\_\_\_\_)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 1785  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William Thomas

(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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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. 56 5- 28

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

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) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 4/2 1936 M. M. Brown

Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 2 1936

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

I first saw \_\_\_\_\_ 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:  
acute intestinal obstruction Date of onset \_\_\_\_\_

Other contributory causes of importance:  
interruption of descending aorta

Name of operating \_\_\_\_\_ 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) R. V. Stapp, M. D.  
(Address) 230 Craig Bldg  
K. C. Mo

SUPERSEDED

RECEIVED

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.

S-15081

SECRET