

DEC'D FEB 21 1939

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

1493

Do not use this space.

1. PLACE OF DEATH

(a) County AudrainRegistration District No. 23(b) Township LoutrePrimary Registration District No. 5032A

Registered No. _____

(c) City Benton City

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Cora May Thompson(a) Residence, No. _____ St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------------------|----------------------------------|---|
| 3. SEX <u>Female</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u> |
|-------------------------|----------------------------------|---|

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clarence Thompson6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 27, 1869

| | | | | |
|--------|-----------|----------|-----------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
| | <u>69</u> | <u>3</u> | <u>12</u> | |

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as 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) Pleasant Plains Illinois13. NAME John Foley14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.15. MAIDEN NAME Margarie Provine16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.17. INFORMANT (ADDRESS) Clarence Thompson Benton City, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Benton City DATE Jan. 10 193919. FUNERAL DIRECTOR (NAME) H.A. Precht & Son (ADDRESS) Mexico, Mo.20. FILED Jan 10 1939 Newa Hutcherson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 8 193922. I HEREBY CERTIFY, That I attended deceased from Jan 10 1939, to Jan 8 1939I last saw her alive on Jan 8 1939. Death is said to have occurred on the date stated above, at 8:15 A.M.

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

Heart failure
Tuberculosis ✓

Date of onset

Other contributory causes of importance:

Tuberculosis

Name of operation _____ Date of _____

What test confirmed diagnosis? Tuberculosis 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 _____, 1939

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? NoIf so, specify _____ (Signed) G. F. Toolson, M. D.(Address) Mexico Mo.

22

RECEIVED

District Health Officer No. 10

District File Number 10-39-32

Date Filed FEB 7 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Earl E. Precht, or by

Registered Apprentice No., working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI DEPARTMENT OF HEALTH
ST. LOUIS, MISSOURI
FEB 10 1939

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1493

Do not use this space.

1. PLACE OF DEATH

(a) County Audrain Registration District No. 23
 (b) Township Route Primary Registration District No. 2032A Registered No. _____
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Cora May Thompson
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W
 (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-8-1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

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

I last saw h. _____ 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:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 3 12

Heart failure
 Tuberculous

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:
 Tuberculous
 Lungs.

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19____

Local Registrar.

SUPPLEMENTAL

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, very important.

