

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REC'D APR 11 1939

10070

Do not use this space.

1. PLACE OF DEATH

- (a) County Buchanan, Registration District No. 85
 (b) Township Washington Primary Registration District No. 1001 Registered No. 225
 (c) City St. Joseph, (d) Street No. Missouri Methodist Hospital, 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. 2 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank William Thompson,

- (a) Residence, No. _____ St. Hatfield, Missouri,
 (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>Male</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 <u>Bertha M. Thompson,</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept. 22, 1860</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>5</u>	DAYS <u>14</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Buyer,</u>		11. Total time (years) spent in this occupation <u>50</u>
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Cattle,</u>		
10. Date deceased last worked at this occupation (month and year) <u>March 1939</u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Hatfield, Missouri,</u> <u>0</u>		
13. NAME <u>David Thompson,</u> <u>4</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Scotland,</u> <u>1</u>		
15. MAIDEN NAME <u>Rebecca Knox,</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Pennsylvania,</u>		
17. INFORMANT <u>Mrs. Frank W. Thompson,</u> (ADDRESS) <u>Hatfield, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Hatfield, Mo.</u> DATE <u>March 6th, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Henton-Bellah, Bann,</u> <u>319 So. 10th. St. Lawrence,</u>		
20. FILED <u>Mar 6, 1939</u> <u>H. J. Kellison,</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1939, to Mar. 6, 1939.
 I last saw him alive on Mar. 6, 1939. Death is said to have occurred on the date stated above, at 3:40 p.m.
 The principal cause of death and related causes of importance were as follows:
Acute Nephritis Date of onset _____
 Other contributory causes of importance:
Retention of Urine

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical 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 Charles Geiger, M. D.
 (Signed) _____ (Address) 701 Garwood St.
St. Joseph, Mo.

120

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, 3/6/18

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed

Harold Bowman

Licensed Embalmer No. 3619

P. O. Address 319 So 10th St

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.

bbjico

LA 11541011

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10070
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 88-
(b) Township _____ Primary Registration District No. 1001 Registered No. 225-
(c) City St. Joseph (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

Frank William Thompson
(a) Residence, No. _____ St. (If non-resident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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.
78 5 14

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 130

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 6, 1939

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

I instructed _____ to be 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 nephritis

Date of onset _____

Other contributory causes of importance:

Retention of urine

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) Charles Geiger, M. D.

(Address) 201 Faraon St. Joseph Mo

SUPPLEMENTARY COPY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AND PRESCRIBED BY LAW.
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 - 3 1959