

SEP 15 1938

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

28477  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Audrain Registration District No. 26  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3002 Registered No. 123  
 (c) City Mexico Mo. (d) Street No. Audrain 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clarence S. Thompson  
 (a) Residence, No. Benton City Mo 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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 12 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81 6 29

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

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 11 1939

22. I HEREBY CERTIFY, That I attended deceased from July 27 1938 to Aug 11 1939  
 I last saw him alive on Aug 11 1939 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:

Chronic Degeneration myocarditis  
ischemic  
premiu-793C

Date of onset

Other contributory causes of importance:  
Atherosclerotic degeneration

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) J. J. Harrison M. D.  
 (Address) Mexico Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

FATHER 13. NAME unknown 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) R. P. Rodgers Mexico Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Benton City Mo DATE Aug 13 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Smith's Bros Mexico Mo

20. FILED Aug 12 1939 Blanche Heely Local Registrar

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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RECEIVED.

District Health Officer No. 10

District File Number 4-39-1581

Date Filed SEP 8 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,

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Ray McPherson - McPherson*

Licensed Embalmer No. 1123

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.