REG'D SEP 12 1939

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

29163
Do not use this space.

1. PLACE OF DEATH
(a) County: Greene
(b) Township or City: /
(c) City: Springfield, Mo
Registration District No.: 318
Primary Registration District No.: 2001
Registered No.: 646
(d) Street No.: City 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: George N. Thompson
(a) Residence, No.: 512 1099 E Chestnut 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 28 - 1869
7. AGE: Years 69 | Months 11 | Days 22 | If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
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.: Unemployed
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): Webster Co Mo

FATHER
13. NAME: Geo. W. Thompson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Penn.

MOTHER
15. MAIDEN NAME: Mary Flora
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Penn.

17. INFORMANT: F. M. Thompson
(ADDRESS): West Plaines Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Dodd Hope DATE: Aug. 22, 1939
19. FUNERAL DIRECTOR (NAME): McMahan Funeral Home
(ADDRESS): Springfield Mo
20. FILED: Aug 20, 1939 Chas A George M.D.
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug 20, 1939
22. I HEREBY CERTIFY, That I attended deceased from Aug. 3rd, 1939, to Aug 20, 1939
I last saw h. alive on Aug 20, 1939 Death is said to have occurred on the date stated above, at 4:15 P m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Myocarditis, Chronic | |

Other contributory causes of importance: General Toxemia following Prostatectomy

Name of operation: Prostatectomy Date of: Aug 12 1939
What test confirmed diagnosis: Clinical Exam 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?
If so, specify
(Signed) J. Newton Wakeman, M. D.
(Address) 290 Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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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## 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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

29163
Do not use this space.

1. PLACE OF DEATH
(a) County Greene — Registration District No. 318
(b) Township — Primary Registration District No. 2001 — Registered No. 646
(c) City Springfield — (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 George W. 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Div

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

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

7. AGE: YEARS 69 — MONTHS 11 — DAYS 22 — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
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

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

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

MOTHER
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 Oct 2, 1939 Chas A George MD
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..
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:
Myo Carditis - chronic — Date of onset
93 C
Other contributory causes of importance:
General Toxemia following Prostatectomy
Hypertrophy of Prostate (non-malignant)
Name of operation Prostatectomy — Date of .....
What test confirmed diagnosis? Biopsy — 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? .....
If so, specify .....
(Signed) J. Newton Wakeman M. D.
(Address) Springfield Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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