

REC'D SEP 22 1939

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

29636
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 528
(b) Township Dallas Primary Registration District No. 5704
(c) City or _____ (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 W. O. Thomas

(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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 8 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 10 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Macon Mo

13. NAME J E Thomas

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris

15. MAIDEN NAME Mary L James

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Willard Thomas
Dallas Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Dallas Mo DATE Aug 3 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Allet Skinner
Macon Mo

20. FILED 9-11 1939 N. H. Bacon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 2nd 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1939 to Aug 2nd 1939
I last saw him 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:

Accidentally Drowned Date of onset Smith

Other contributory causes of importance:
Alk in her wms
Drinking

Name of operation _____ Date of _____
What test confirmed diagnosis Obser J. Inquest Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide Accident Date of injury Aug 2 1939
Where did injury occur? 3 mi South East of New Damb
in old mill (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Drowned
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____
(Signed) Robert L. ... M. D.
New Damb Mo (Address)

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.

Newspaper report - Car missed
the bridge and went over
into the river #

M 5

RECEIVED

District Health Officer No. 10

District File Number 9-397681

Date Filed SEP 18 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.....

George H. Hile
working under my personal supervision.

....., Registered Apprentice No.....

Signed *George H. Hile*

Licensed Embalmer No. 4066

P. O. Address. *Macon, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29686

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 528
 (b) Township Collins Primary Registration District No. 3704 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 Warren Omer Thomas

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 29, 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.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 10 24

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

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 _____

Date of onset _____

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

Other contributory causes of importance: _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

Name of operation _____ Date of _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

What test confirmed diagnosis? _____ Was there an autopsy? _____

17. INFORMANT (ADDRESS) _____

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.

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

Manner of injury _____

Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS) _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. O. West Coroner

(Address) New Cambria, Mo.

20. FILED _____ 19 H. J. Bacon Local Registrar

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.

