

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 429461 JAN 9 1939  
Registration District No. 104Primary Registration District No. 5153Registrar's No. 3331

## 1. PLACE OF DEATH:

(a) County Callaway *IND*  
 (b) City or town Rural - Fulton *11*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 19 Yrs  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. South of Fulton 5 miles  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15th  
 year 1939 hour 12 minute 15 M.

21. I hereby certify that I attended the deceased from  
Dec 14, 1939, to Dec 15, 1939  
 that I last saw him alive on Dec 15, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 12-14 39

Due to Cardio-vascular  
Hypertension  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death) *ASV?*

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged statistically

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_  
 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

28. Signature W. O. Payne (M. D. or other) 1  
 Address Rt 6 Fulton Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Fay Freemont Thomas 520

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosa Thomas 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
Rosa Thomas

7. Birth date of deceased December 12 1870  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 00 3 hr. \_\_\_\_\_ min.

9. Birthplace Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming 1

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jacob Thomas 1

18. Birthplace Ohio 1  
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Weible (State or foreign country)

15. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rosa Thomas

(b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof December 17  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Carmel

18. (a) Signature of funeral director Ray C. Holt

(b) Address New Bloomfield, Missouri

19. (a) Dec. 16, 1939 (b) R. M. Cruver 106  
 (Date received local registrar) (Registrar's signature)

**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~~ \_\_\_\_\_

Ray A. Holt  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed Ray A. Holt

Licensed Embalmer No. 2609

P. O. Address New Bloomfield

**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.**