

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44018

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 338

1. PLACE OF DEATH:

(a) County Marion 2  
(b) City or town Nannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2615 Laclède St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Not in hospital  
(Specify whether years, months or days) Sixty-nine years

3. (a) PRINT FULL NAME Joseph Calvin Thomas 520

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. none

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

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

7. Birth date of deceased July 10, 1864  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 25 If less than one day hr. min.

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

10. Usual occupation Retired 15 years

11. Industry or business Farmer

12. Name Edward Thomas

13. Birthplace (Not known) Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Maria Campbell

15. Birthplace (Not known) Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. F. Powers

(b) Address Nannibal, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1939  
(Month) (Day) (Year)

(c) Place: burial or cremation Not Zion Cemetery

18. (a) Signature of funeral director Ray P. Schwartz

(b) Address Nannibal, Missouri

19. (a) Dec 9, 1939 (Date received local registrar) (b) W. F. Powers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Nannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2615 Laclède  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 8<sup>th</sup>  
year 1939 hour 2:35 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Dec 6-20  
1939, 1939, to Dec 8, 1939  
that I last saw him alive on Dec 6, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (bronchial) Duration 6 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1072

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. F. Powers (M. D. or other) \_\_\_\_\_

Address Nannibal, Mo Date signed Dec 9, 1939

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

STATE BOARD OF HEALTH  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
MICHIGAN

**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 P. Schwartz*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Ray P. Schwartz*.....  
Licensed Embalmer No. *1768*.....  
P. O. Address *Hannibal, 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

44018  
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547  
(b) Township ..... Primary Registration District No. 3029 Registered No. 338  
(c) City Hannibal (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

Joseph Calvin 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10 1864

7. AGE YEARS 74 MONTHS 4 DAYS 28 If LESS than 1 day, ..... hrs. or ..... min.

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) .....

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 .....

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED 2/7 19 40 Em. Rucker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 8 1937

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:

Date of onset

Other contributory causes of importance:

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) W. J. Frustrera M. D.  
(Address) Hannibal, Mo.

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 in terms of years, months, and days. If the state of mind of the deceased is important, it should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION, if any, should be given.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

SUPPLEMENTARY

BRADLEY'S

1888