

FILED FEB 13 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2458

Registrar's No. 2

Registration District No. 318

Primary Registration District No. 5440

1. PLACE OF DEATH:

(a) County GREENE S. C. 2
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Medical Center for Federal Prisoners
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Mo. 13 days
 In this community Same (Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMPSON, Fred 512

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 11 1908
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
↓ 31 8 21 hr. min.9. Birthplace Knoxville, Tennessee
(City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business

12. Name Albert Thompson13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Lula Lumpkin
(City, town, or county) (State or foreign country)15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Deceased

(b) Address _____

17. (a) Burial (b) Date thereof 1-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Springfield, Mo. Eastlawn Ave18. (a) Signature of funeral director Thieme Funeral Home(b) Address Springfield, Mo. 29919. (a) 1-5-40 (b) Chas a George MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Dist. Columbia (b) County _____(c) City or town Washington
(If outside city or town limits, write "RURAL")(d) Street No. Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1940 hour 7: minute 50 A.M.21. I hereby certify that I attended the deceased from Oct. 19,
1939, 19____, to Jan. 2, 1940, 19____;that I last saw him alive on Jan. 2, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Tuberculosis, pulmonary, chronic,
far advanced, active, bilateralDue to: Pyopneumothorax

Due to _____

Other conditions TBC of intestines & larynx
(Include pregnancy within 3 months of death)Major findings: TuberculosisOf autopsy Tuberculosis

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? No (Specify type of place) _____
(e) Means of injury _____23. Signature [Signature] (M. D. or other) _____Address MCFP-Springfield, Mo. Date signed 1-5-40

Duration

Prior

to ad-

mission

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically

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.....

Self
....., Registered Apprentice No.
working under my personal supervision.

Signed *R. Williams*
.....

Licensed Embalmer No. *3681*
.....

P. O. Address *S. M.*
.....

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.

X