

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED MAY 1 1940

Registration District No. 562

Primary Registration District No. 5757

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Miller
(b) City or town Rural - Richwoods
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
In this community Driving through (Specify whether years, months or days) 5/17

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Leede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME PRESTON THOMPSON
3. (b) If veteran, name war World War 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 14
year 1940 hour 7 minute 30 A. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

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 March 22 - 1887
(Month) (Day) (Year)

that I last saw h _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 23 Days _____ If less than one day hr. _____ min. _____

Immediate cause of death
Fracture base of skull & fracture of cervical vertebrae with associated cord injury
Due to falling into wreck
Due to fracture left parietal and temporal bones
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations none
Of autopsy none

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

10. Usual occupation Surgeon & M.D.

11. Industry or business
12. Name E. C. Thompson
13. Birthplace Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Alice Craft
15. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Olmer Thompson
(b) Address Crumley Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Apr 14, 1940
(c) Where did injury occur? Crocker Bovera, Road
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On highway Miller Co. Mo.
(Specify type of place)
While at work? Yes Means of injury Auto wreck

(c) Place: burial or cremation Crumley Mo.

18. (a) Signature of funeral director E. L. Casey
(b) Address Abria Mo.

19. (a) Apr 22 (b) Max W. Jones
(Date received local registrar) (Registrar's signature)

23. Signature E. M. Blitt (M. D. or D.D.S.)
Address Crumley Mo. Date signed 4-15-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I X1931

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.

210 m
90

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.....

Laron Adams....., Registered Apprentice No. 211
working under my personal supervision.

Signed Chasey.....

Licensed Embalmer No. 2694.....

P. O. Address Bozonia, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12-491

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 362

Primary Registration District No. 5757

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
ROWENA MOORE

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Peachwood, T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Preston Thompson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 33 Months _____ Days 23 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

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

20. DATE OF DEATH Month Apr day 14 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture base of skull + Cervical vertebrae fractured and dislocated and injury auto accident 2/10/40

Due to _____

Due to _____

Other condition Fracture of left frontal and temporal bone
(Include pregnancy within 3 months of death)

Major findings: None collision

Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence April 14, 1940

(c) Where did injury occur? Mar Crocker Piller Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No

While at work? No (Specify type of place) (e) Means of injury on roof

23. Signature C. Mallette (M. D. or other)

Address Crocker Ave Date signed 6-14-40

C. Mallette

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

