

Registration District No. 843Primary Registration District No. 6106

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Stone Washington
 (b) City or town Galena Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
at home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether

In this community _____
years, months or days)8. (a) PRINT FULL NAME William J. Thomas 510

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased Dec 12 1894
(Month) (Day) (Year)8. AGE: Years 55 Months 4 Days 6 If less than one day _____ hr. _____ min.9. Birthplace Mo. (City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Burdell Thomas18. Birthplace Unknown (City, town, or county) (State or foreign country)14. Maiden name Rebecca Maples15. Birthplace Unknown (City, town, or county) (State or foreign country)16. (a) Informant's own signature Raymond Thomas(b) Address Galena Mo17. (a) Rural (b) Date thereof 4-26-49
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Galena Mo18. (a) Signature of funeral director George H. Markham(b) Address Mo. 716519. (a) Apr 25, 49 (b) Nellie Ironby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Stone
 (c) City or town Rural - Washington
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1949 hour _____ minute _____ P. M.21. I hereby certify that I attended the deceased from Apr 23-
_____, 1949, to Apr 25, 1949;that I last saw him alive on Apr 25, 1949;
and that death occurred on the date and hour stated above.

Immediate cause of death

Meningitis Duration 2 daysDue to Frontal sinusitis 10 days

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: none

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?

While at work? no (Specify type of place) (e) Means of injury _____23. Signature H. L. Kerr (M. D. or other)Address Craze Mo. Date signed 4-26-49

RECEIVED

District Health Officer No. 6,

District File Number 540-1219

Date Filed MAY 6 1940

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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.