

2  
1-40  
39  
23159

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. 114

1. PLACE OF DEATH:

(a) County Wodaway

(b) City or town Marysville

(c) Name of hospital or institution: St. Francis Hospital  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether)

In this community 17 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wodaway

(c) City or town Rural  
(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) FULL NAME Francis Marion Thompson

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 Widowed

6. (b) Name of husband or wife Ada V. Thompson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr 3 - 1862  
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Farmer

12. Name Joseph Thompson

13. Birthplace St. Joseph Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Viola Bridgman

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

16. (a) Informant My Walter Kelley

(b) Address Wearmouth Mo.

17. (a) Rural (b) Date thereof Aug 24 40  
(Burial, cremation, or removal) (Month) (Day)

(c) Place: burial or cremation St. Francis Hospital

18. (a) Signature of funeral director James E. Clardy  
(b) Address Clayton, Mo.

19. (a) Aug 27 - 40 (b) James E. Clardy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 8/21/40 to 8/22/40  
that I last saw her alive on 8/21/40 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic pulmonary tuberculosis

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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? Yes

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

(e) Means of injury \_\_\_\_\_

Signature J. W. King (M. D. or other) MD

Address Worshipers Mo. Date signed 8/22/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**