

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 792

Primary Registration District No. 6030

Registrar's No. _____

1. PLACE OF DEATH: **FILED OCT 23 1940**

(a) County Saline
 (b) City or town Rural-Turners Rock
 (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 2
 (Specify whether _____)
 In this community 65 years
 years, months or days)

3. (a) PRINT FULL NAME William D Thomas
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex Male **5. Color or race** White
8. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louise Thomas **6. (c) Age of husband or wife if** 59 years
7. Birth date of deceased Jan 10 1875
 (Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farm

11. Industry or business _____
MOTHER { **12. Name** William B. Thomas
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Maggie Wood
15. Birthplace Saline Co Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Louise Thomas
(b) Address Naples Mo

17. (a) Burial **(b) Date thereof** Sept 18 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Turners Rock Cem

18. (a) Signature of funeral director Cambridge Lewis
(b) Address Market Mo

19. (a) 9-23-40 **(b)** P. L. Lawless
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Saline
 (c) City or town Rural-Turners Rock
 (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 Sept day 16
 year 1940 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 1
 _____, 1930 to Sept 18, 1940
 that I last saw him alive on Sept 14, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage

Due to Hypertension, Chronic
degenerative myocarditis,
 Due to and other complications

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

Major findings: _____
 Of operations 121
 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? _____

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

23. Signature R. W. Stanger (M. D. or other) _____
 Address Nelson Date signed 9/17/40

Duration _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 9-24-40

V

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 W. Campbell

Licensed Embalmer No. 3469

P. O. Address Marshall

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, above space should be left blank.