

Registration District No. 288

Primary Registration District No. 5406 4172 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Kennett Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community About 21 years
years, months or days

3. (a) PRINT FULL NAME Delia Thompson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Bob Thompson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 4 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>10</u>	<u>10</u>	hr. _____ min.

9. Birthplace Don't know Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Simon Brown
13. Birthplace Don't know Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Don't know Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Gibson
(b) Address Kennett Mo

17. (a) Burial (b) Date thereof 3-15-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge Cem

18. (a) Signature of funeral director John W. W. Co

(b) Address Kennett Mo

19. (a) 3-18-41 (b) Dr. Whelan Davis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dunklin
(c) City or town Kennett Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 105 Harrison St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14
year 1941 hour 10 minute 35 A.M.

21. I hereby certify that I attended the deceased from Mar 1, 1941, to Mar 14, 1941; that I last saw her alive on Mar 13, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage

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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address Kennett Mo Date signed 3-15-41

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

RECEIVED

District Health Officer No. 2,

District File Number 441-472

Date Filed 4/10/41

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, fact should be so stated above.

Registration District No. 288

Primary Registration District No. 4172

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Kennett
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Delia Thompson

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

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

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

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

8. AGE: Years 70 Months 10 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation home work

11. Industry, or business home

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-18-41 (Date received local registrar) (b) Wheeler Davis (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to _____
Due to _____

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

Major findings: _____
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? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. C. Cooper (M. D. or other) _____
Address Kennett Mo. Date signed _____

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

SUPPLEMENTARY

RECEIVED

District Health Officer No. 2,

District File Number _____

Date Filed _____

S-10578-1941

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, fact should be so stated above.