

FILED JUL 17 1941

Registration District No. **627**Primary Registration District No. **5899**

Registrar's No.

1. PLACE OF DEATH:

- (a) County Nodaway
 (b) City or town Pickering (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3 mi S. East.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 8 yrs.
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Nodaway
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3 mi. S. E. of Pickering
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June, day 17,
 year 1941 hour 11 minute 30 a. M.
 21. I hereby certify that I attended the deceased from April
28 1941, to June 11 1941;
 that I last saw him alive on May 28 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death:

Organic Heart Disease

Duration

Due to _____

Due to _____

Other conditions: Anasarca
 (Include pregnancy within 3 months of death)

Major findings:

Of operations no operationOf autopsy NO autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?
87th _____ (Specify type of place)
 While at work? _____ Means of injury _____

23. Signature Ernest L. Brown (M. D. or other) (1)
 Address Pickering Mo. Date signed 7-13-413. (a) PRINT FULL NAME JEFFERSON DAVIS THOMAS3. (b) If veteran, name war no. 3. (c) Social Security No. none4. Sex M. (1) 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Sept. 13, 1865
 (Month) (Day) (Year)8. AGE: Years 75 Months 8 Days 29, If less than one day
 hr. _____ min. _____9. Birthplace Buchanan Co., Mo.
 (City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business _____

12. Name John Thomas13. Birthplace Tenn.
 (City, town, or county) (State or foreign country)14. Maiden name Sally Dance15. Birthplace Virginia
 (City, town, or county) (State or foreign country)16. (a) Informant Walter Rynnels(b) Address Pickering Mo.17. (a) Burial (b) Date thereof June 13, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation White Oak Cemetery18. (a) Signature of funeral director John W. Price(b) Address Maryville Mo.19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

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.....

John W. Price

Licensed Embalmer No. *3229*

P. O. Address.....

Maryville 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, fact should be so stated above.

Registration District No. 627

Primary Registration District No. 5829

1. PLACE OF DEATH

(a) County nodaway.
(b) City or town _____
(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 Jefferson Davis Thomas

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 _____ years

7. Birth date of deceased Sept. 13 1865
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one year _____ hr. _____ 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) JUNE 17 1941 (b) MR. J. C. HACKETT
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 11
year _____ 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 _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

