FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29684
Do not use this space.

11

1. PLACE OF DEATH
(a) County Webster — Registration District No. 896
(b) Township Ozark — Primary Registration District No. 6198 — Registered No. 25
(c) City — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. PRINT FULL NAME Carley P. Thomas Sr.
(a) Residence, No. ..... St. ..... (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16, 1854
7. AGE — YEARS 87 — MONTHS 6 — DAYS — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshfield Mo.

FATHER
13. NAME James D. Thomas
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER
15. MAIDEN NAME Lucinda Stubbins
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT (ADDRESS) Josie E. Thomas Marshfield Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Kinnings Cemetery DATE July 18 1941
19. FUNERAL DIRECTOR (NAME) (ADDRESS) McMahan Funeral Service Marshfield Mo.
20. FILED Aug 30 41 19 Elizabeth Highfire Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16, 1941
22. I HEREBY CERTIFY, That I attended deceased from July 1, 19.., to July 14, 1941
I last saw him alive on July 14, 1941. Death is said to have occurred on the date stated above, at 6 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocardosis	—
Chronic Nephritis	
Diabetes Mellitus	

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Other contributory causes of importance: Prostatic Hypertrophy

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) M. D. Spencer, M. D.
(Address) Marshfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 6
District File Number 941-1450
Date Filed SEP 9 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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29684

Registration District No. 896 Primary Registration District No. 6199 Registrar's No. 25

1. PLACE OF DEATH:
(a) County: Webster
(b) City or town: Ozark Twp (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 years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Webster
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: Mansfield York Twp. (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Charley P. 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: Feb. 16 1854 (Month) (Day) (Year)
8. AGE: Years 87 Months 6 Days ____ (If less than one day) hr. ____ min.
9. Birthplace: ____ (City, town, or county) ____ (State or foreign country)
10. Usual occupation: ____
11. Industry or business: ____
FATHER 12. Name: ____
FATHER 13. Birthplace: ____ (City, town, or county) ____ (State or foreign country)
MOTHER 14. Maiden name: ____
MOTHER 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) 10/15/41 (Date received by local registrar) (b) J. R. Bruce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1941 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	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? ____ (Specify type of place)
While at work? ____ (e) Means of injury: ____
23. Signature: ____ (M. D. or other)
Address: ____ Date signed: ____

SUPPLEMENTARY