

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20945
State File No. _____
Registrar's No. 47

FILED JUL 13 1942
Registration District No. 281

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay Liberty
(b) City or town Liberty
(c) Name of hospital or institution: Home 133 S. Missouri St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
(c) City or town Liberty
(If outside city or town limits, write "RURAL")
(d) Street No. 33 S. Missouri St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

3. (a) PRINT FULL NAME John F. Thomas
3. (b) If veteran, name war none 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 27 year 1942 hour 2:30 minute 30 A.M.

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced widowed
7. Birth date of deceased December 17 - 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1, 1942, to June 27, 1942 that I last saw him alive on June 25, 1942 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>6</u>	<u>10</u>	hr. min.

Immediate cause of death
Terminal Pneumonia
Fracture neck of rt femur
Due to Cerebral Hemorrhage

9. Birthplace Fleming Mass Ky
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)
Due to _____

10. Usual occupation Tobacco Dealer

Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Walter
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace 9
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant's own signature W. F. Thomas
(b) Address 140 S. Leavelle Liberty Mo
17. (a) Burial (b) Date thereof June 28 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation Liberty Mo
18. (a) Signature of funeral director Charles Archert Co
(b) Address Liberty Mo
19. (a) 6-27-42 (b) Walter Early
(Date received local registrar) (Registrar's signature)

23. Signature H. R. Schumacher (M. D. or other) M.D.
Address Liberty Mo Date signed 6-27-42

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

Rev. 5-17-39
1 X1951

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.

PHYSICIAN
Underline the cause to which death should be charged statistically
Duration
5 days
3 weeks
3 yrs

RECEIVED

District Health Officer No. 8,

District File Number

7-10-42

Date Filed

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 Edgar Archer

Licensed Embalmer No. 3311

P. O. Address Liberty 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **90945**
Registrar's No. _____

Registration District No. **201**

Primary Registration District No. **3012**

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

1. PLACE OF DEATH: **Clay Liberty**

(a) County **Clay**

(b) City or town **Liberty**
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John F. 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 **w**

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

7. Birth date of deceased **Dec 17 1868**
(Month) (Day) (Year)

8. AGE: Years **73** Months **6** Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(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 _____ year **1942** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: **fracture neck of rt femur**

Due to _____

Due to _____

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

Major findings: **96**

Of operations _____

Of autopsy _____

Duration

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) **Accident**

(b) Date of occurrence **June 1, 1942**

(c) Where did injury occur? **3 mi N.W. Liberty Clay Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about home

While at work? **no** (Specify type of place) (e) Means of injury **fracture neck of femur**

23. Signature **N.R. Schuhmacher** (M. D. or other) **MD**
Address **Liberty Mo.** Date signed **8-7-42**



