

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED SEP 9 1942

Registration District No. 73

Primary Registration District No. 3014

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Clay Liberty  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days all her life

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. 253 W. Kansas  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ✓ \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17  
year 1942 hour 9 minute 36 A.M.  
21. I hereby certify that I attended the deceased from  
Aug 14, 1942, to Aug 17, 1942  
that I last saw her alive on Aug 14, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage  
Right Cerebrum  
Due to General Arterio  
sclerosis  
Duration 3da  
15 3/4 hr

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 830

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) \_\_\_\_\_  
(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 Arthur M. Malley (M. D. or other) M.D.  
Address Liberty Mo. Date signed 18-8-42

3. (a) PRINT FULL NAME Willie ANN THOMASON

3. (b) If veteran, name war. None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife W. H. Thomason 6. (c) Age of husband or wife at death 89 years

7. Birth date of deceased Jan. 18-1859  
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 29 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

12. Name Irvin Timberlake

18. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country)

14. Maiden name Frances Timberlake

15. Birthplace Clay Co. Mo.  
(City, town or county) (State or foreign country)

16. (a) Informant's own signature W. H. Thomason

(b) Address 253 W. Kansas, Liberty Mo.

17. (a) Burial (b) Date thereof Aug 19 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerary, Liberty Mo.

18. (a) Signature of funeral director Charles Arthur

(b) Address Liberty Mo.

19. (a) Aug 18 1942 (b) Arthur Early  
(Date registered legal registrar) (Registrar's signature)

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

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. 8,

District File Number \_\_\_\_\_

Date Filed 9-2-42

4-1-37

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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.

Form 1 X29288  
M-8-21-41

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26962  
Registrar's No. 63

Registration District No. 73

Primary Registration District No. 3014

1. PLACE OF DEATH:  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days) Life

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Willie Ann Thomason  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug Day 15 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Jan 18 1885  
(Month) (Day) (Year)

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 Cerebral hemorrhage Duration 3da  
General arteriosclerosis

8. AGE: Years 83 Months 6 Days 15 (If less than one day \_\_\_\_\_) min. \_\_\_\_\_

Due to age 15 yrs

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)

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 \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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)

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

SUPPLEMENTARY

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

Buwalda  
Machery

S-26962