

No. 2
0-4-41
7-3-41
X-2

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

FILED SEP 9 1943
Registration District No. **184**

Primary Registration District No. **3038**

1. PLACE OF DEATH:
(a) County **Linn**
(b) City or town **Brookfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McLarney
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6** (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Rola May Thomas**
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 **Married**
6. (b) Name of husband or wife **Walter Thomas** 6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **Jan. 11 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 6 20 hr. _____ min.

9. Birthplace **Fulton Co. Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **housekeeper**

11. Industry or business
12. Name **Scott J Smith**
13. Birthplace **Illinois**
14. Maiden name **Ella M Long**
15. Birthplace **Illinois**

16. (a) Informant **Scott J Smith**
(b) Address **Marceline Mo**
17. (a) **Burial** (b) Date thereof **Aug 4 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St Olivet**
18. (a) Signature of funeral director **James M Laughlin**
(b) Address **Marceline Mo**
19. (a) **8-4-1943** (b) **W H Cannon**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Linn 58**
(c) City or town **Marceline 2**
(If outside city or town limits, write "RURAL")
(d) Street No. **126 W. Booker!**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **1**
year **1943** hour **6** minute **A.M.**
21. I hereby certify that I attended the deceased from **July 26**, 19**43**, to **Aug 1**, 19**43**
that I last saw her _____ alive on **July 31**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute congestive heart failure** Duration _____
Due to **depression from an abdominal operation for the removal of a cystic tumor**
Due to _____

Other conditions **enlarged thyroid gland**
(Include pregnancy within 3 months of death)
Major findings: **large ovarian tumor**
Of operations _____
Of autopsy **none**

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 **P. J. Patrick** (M. D.)
Address **Marceline Mo** Date signed **8-2-1943**

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 Blanche M Lang
Licensed Embalmer No. 1904
P. O. Address Marcelin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 184

Primary Registration District No. 3028

Registrar's No. 216

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McLarney
(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 Lela May Thomas

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 m

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

7. Birth date of deceased: Jan 11 1911
(Month) (Day) (Year)

8. AGE: Years 46 Months _____ Days _____ If less than one day _____ 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) _____ (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 Aug Day 1 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 acute congestive heart failure Duration _____

Due to depression from an abdominal operation for the removal of a cystic tumor.

Other conditions enlarged thyroid gland (Include pregnancy within 3 months of death)

Major findings: Of operations large ovarian

Autopsy Non-malignant

22. Death was due to external causes, all being the following:

(a) for removal of ovarian cyst (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) (c) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTAL

MENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

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