

FILED DEC 29 1943

State File No.

Registration District No. *1*Primary Registration District No. *5572*

Registrar's No.

## 1. PLACE OF DEATH

(a) County *Jackson*  
 (b) City or town *Rural Prairie Inn*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
*Jackson Co. Emory Hospital*  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution *2 days* (Specify whether  
 In this community *5 yrs.* years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Jackson* *48*  
 (c) City or town *Kansas City*  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. *9208 Cherry* (If rural, give location) *8*  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country. *1*

3. (a) PRINT FULL NAME *THOMPSON W. F.*

3. (b) If veteran, name war *NO* 3. (c) Social Security No. *unknown*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *1*

6. (b) Name of husband or wife *Clara Thompson* 6. (c) Age of husband or wife if alive *57* years

7. Birth date of deceased *Oct. 16 1892*  
 (Month) (Day) (Year)

8. AGE: Years *51* Months *1* Days *28* If less than one day  
 hr. min.

9. Birthplace *Bethany Missouri*  
 (City, town, or county) (State or foreign country)

10. Usual occupation *Convent Kinscher*

11. Industry or business *Construction Work*

12. Name *John W. Thompson*

13. Birthplace *unknown* *9*

14. Maiden name *Martha Holter*

15. Birthplace *Bethany Mo*  
 (City, town, or county) (State or foreign country)

16. (a) Informant *Clara Thompson*

(b) Address *9208 Cherry*

17. (a) *Burial* (b) Date thereof *12-17-43*  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Bethany Mo.*

18. (a) Signature of funeral director *H. T. Jigman*

(b) Address *R. P. 7th*

19. (a) (b)

(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *14*  
 year *1943* hour *6* minute *50 A.M.*

21. I hereby certify that I attended the deceased from *Dec 12*, 19*43* to *Dec 14*, 19*43*  
 that I last saw him alive on *Dec 13*, 19*43*  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
*Anemia with contributing factor of renal hemorrhage*

Due to

Due to

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

Major findings:  
 Of operations *103*

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 *F. W. Tuttle* (M. D. or other) *MD*

Address *Blue Springs, Mo* 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

1162

(Licensed Embalmer's Statement on Reverse Side)

APR 14 1942

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.....

*Francis Walter*....., Registered Apprentice No. *2744*  
working under my personal supervision.

Signed *J. A. Peggiman*.....  
Licensed Embalmer No. *2744*  
P. O. Address *K.P. 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.

JAN

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Jessamine  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME W. F. Thompson

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 m

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

7. Birth date of deceased Oct. 16 (Month) (Day) (Year)

8. AGE: Years 51 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 \_\_\_\_\_

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) Dec. 30, 1943 F. M. Schick (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1943 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ live 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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-42576