

Registration District No. _____

Primary Registration District No. **5391**

Registrar's No. **16**

1. PLACE OF DEATH:

(a) County **Dent**
(b) City or town **Texas** *Smoking*
(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 **all his life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dent**
(c) City or town **rural Texas** *Smoking*
(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 **Samuel Houston Thomason**

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

4. Sex **male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Heneratta E. Thomason** 6. (c) Age of husband or wife if live years
7. Birth date of deceased **Feb 4 1868**
(Month) (Day) (Year)

8. AGE: Years **75** Months **10** Days **28** If less than one day hr. _____ min. _____

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

10. Usual occupation **farmer**

11. Industry or business

MOTHER FATHER { 12. Name **James Calvin Thomason**
13. Birthplace _____ **Tenn**
(City, town, or county) (State or foreign country)
14. Maiden name **Harriet Widner**
15. Birthplace _____ **Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. S. F. Dalton**
(b) Address **Salem Mo**

17. (a) **Burialman Cem** (b) Date thereof **Feb-5-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT Herman Cem**

18. (a) Signature of funeral director **Carl J. Tomer**
(b) Address _____

19. (a) **2-5-44** (b) **Geo D. McLeary**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **2**
year **1944** hour **6** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Jan 29 1944** to **Jan 30 1944**
that I last saw him alive on **Jan 30 1944**
and that death occurred on the date and hour stated above.
Immediate cause of death **apoplexy**

Due to **Chronic infarct**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: **121**
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) _____
(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 **Lester Randall** (M. D. or other) _____
Address **Dickinson Mo** Date signed _____

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

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

344186
3-6-44

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. 370
P. O. Address.....
Salem, 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.