

FILED APR 6 1944

State File No.

Registration District No. 65

Primary Registration District No. 4113

Registrar's No.

1. PLACE OF DEATH:

(a) County CHARITON  
(b) City or town BRUNSWICK  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State 21  
(b) County 1  
(c) City or town 5  
(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 0

3. (a) PRINT FULL NAME JOSEPH F. THOMPSON

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

4. Sex MALE 5. Color or face WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife EVA 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased JANUARY 12 - 1861  
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 10 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Nathan Thompson

13. Birthplace Christ (City, town, or county) (State or foreign country)

14. Maiden name Susan Thompson

15. Birthplace Edina (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. F. Thompson

(b) Address Brunswick, MO

17. (a) Burial (b) Date thereof 3-5-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Key toville MO

18. (a) Signature of funeral director W. Weiser

(b) Address Brunswick, Missouri

19. (a) 3-5-1944 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2 year 1944 hour 11 minute 9 P. M.  
21. I hereby certify that I attended the deceased from March 7, 1944, to March 7, 1944, that I last saw him alive on March 7, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Nephritic Arteriosclerosis

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death) 131a

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 J. Steyer (M.D. or other) D.D.  
Address Brunswick, MO Date signed 3/2-44

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

4-5-47

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.....

*L. M. Weisheit*

Licensed Embalmer No.....

822

P. O. Address.....

*Bruce...*

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. 65

Primary Registration District No. 4113

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Brunswick  
(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 Joseph 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 Jan 12  
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

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

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) 3-5-1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Brunswick Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 12 Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive 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) (c) Means of injury \_\_\_\_\_

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

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

SUPPLEMENTARY

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

MOTHER FATHER

10071