No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 8 1944

Registration District No. 749

Primary Registration District No. 1002

State File No. 20908

Registrar's No. 2628

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days 0 (Specify whether
In this community 15 years
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. 15 E. 6th St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Thompson, John

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 93 ~~91~~ | Months | Days | If less than one day hr. min.

9. Birthplace New York (City, town, or county) 1 (State or foreign country)

10. Usual occupation Printer

11. Industry or business

FATHER
12. Name John Thomson
13. Birthplace New York (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Margaret
15. Birthplace Not known (City, town, or county) 9 (State or foreign country)

16. (a) Informant Hospital Records
(b) Address 18 C Gen Hospt 1 #

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Snow-Mayberry
(b) Address Linwood - Olive

19. (a) 6-22-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1944 hour 2 minute 15 p M.

21. I hereby certify that I attended the deceased from June 15, 1944, to June 21, 1944 that I last saw him alive on June 21, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Malnutrition-senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 162 b	

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?
(Specify type of place)
While at work (e) Means of injury 0

23. Signature A. E. Upcher (M. D. or other) M.D.
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address Ft C 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.