

FILED FEB 8 1945

Registration District No. 350Primary Registration District No. 3072

State File No. _____

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Marshall, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Fitzgibbon Hospital
 (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)

3. (a) PRINT FULL NAME John Robert Thomas

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

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

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

7. Birth date of deceased Jan. 10 1945
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days _____ If less than one day
hr. _____ min. _____9. Birthplace Marshall Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business _____

12. Name John T. Thomas13. Birthplace Sweet Springs Mo.
(City, town, or county) (State or foreign country)14. Maiden name Cora Bell Howery15. Birthplace Saline Co. Mo.
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. James Walker(b) Address Marshall, Mo.17. (a) Burial (b) Date thereof 1/11/1945
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sunset Memorial Gardens18. (a) Signature of funeral director J. J. Sullivan(b) Address Marshall, Mo.19. (a) 1-11-45 (b) Mo. T. Overbrook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97
 (c) City or town Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. North Lyon
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11
year 45 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from Jan 10 - 45
_____, 19____ to Jan 11, 1945
that I last saw him alive on Jan 11
and that death occurred on the date and hour stated above. 1945

Immediate cause of death _____ Duration _____

PrematureDue to unknown

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

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? _____

18. (a) Signature of funeral director _____ (Specify type of place)

(b) Address _____ (c) Means of injury _____

23. Signature John R. Lawrence (M. D. or other) _____
Address Marshall, Mo. Date signed Jan 11 1945

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-7-45

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 J. Isalic Surmacy
Licensed Embalmer No. 32351
P. O. Address 911 Marshall St.

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.

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Marshall
 (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 _____ years, months or days

3. (a) PRINT FULL NAME John Robert Thomas

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 5

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

7. Birth date of deceased Jan 10 1945
 (Month) (Day) (Year)

8. AGE: Years _____ 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 _____
 (Burial, cremation, or removal) (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 _____ year 1945 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 _____

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 John R. Thomas (M. D. or other) _____
 Address Marshall, Mo Date signed Feb 10

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

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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