

FILED FEB 8 1945

State File No.

Registration District No. 324

Primary Registration District No. 6092

Registrar's No. 1

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Malta Bend Rural
(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 60 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline 97
(c) City or town Shackelford
(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 Annie Reed Panney Thompson
(b) If veteran, name war _____ (c) Social Security No. Nane
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Charles James Thompson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 10th, 1861
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 22 year 1944 hour 9 minute 45 A.M.
21. I hereby certify that I attended the deceased from Dec 1 to Dec 22, 1944
that I last saw or alive on Dec 10, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years Months Days If less than one day
83 2 12 hr. min.

Due to _____
Due to _____
Other conditions (Includes pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Halifax, Nova Scotia
(City, town, or county) (State or foreign country)
10. Usual occupation House keeper
11. Industry or business _____
12. Name William Penney
13. Birthplace Nova Scotia
(City, town, or county) (State or foreign country)
14. Maiden name Margaret
15. Birthplace N.S.
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant Mr. Albert Robertson
(b) Address Malta Bend, Mo.
17. (a) Burial (b) Date thereof Dec. 24, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Salt Springs cemetery
18. (a) Signature of funeral director Campbell Lewis
(b) Address Marshall, MO.
19. (a) 1-16-45 (b) _____
(Date received local registrar) (Registrar's signature)

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 Robert A. Campbell (M. D. or other) _____
Address _____ Date signed 1/20/45

RECEIVED

Public Health Officer No. 8,

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.....

Licensed Embalmer No. 3469

P. O. Address. Marshall Ma

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15eb
Registrar's No. 1

Registration District No. 324 Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Rural Grand Pass Ferry
(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 Amiel R. P. Thompson

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased Oct 10 1906
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days _____ If less than one day _____ min.

9. Birthplace Bohota Scouts
(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) 1-16-45 (b) T.P. Neethal Dip.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(g) 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 Dec Day 2 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 _____

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

SUPPLEMENTARY

3714

MAR 27 1945