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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 10 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 274

Primary Registration District No. 4547

1. PLACE OF DEATH:  
(a) County North  
(b) City or town Grant City  
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County North 112  
(c) City or town Grant City 1  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_ 11

3. (a) PRINT FULL NAME Pearl D. Thompson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 21  
year 1945 hour 4 minute 30 P.M.  
21. I hereby certify that I attended the deceased from Nov 10, 1944 to Jan 21, 1945  
that I last saw her alive on Jan 21, 1945  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife A. F. Thompson 6. (c) Age of husband or wife if alive dead years  
7. Birth date of deceased March 8, 1880 (Month) (Day) (Year)

Immediate cause of death Hypertensive Heart Disease Duration 2 yrs.

8. AGE: Years 64 Months 10 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Grant City Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name William H. Hays  
13. Birthplace Ohio (City, town, or county) (State or foreign country)  
14. Maiden name Sarah M. Hays  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

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

16. (a) Informant Verna Thompson  
(b) Address Grant City, Mo.  
17. (a) Burial (b) Date thereof 1-25-45 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grant City, Mo.  
18. (a) Signature of funeral director Jack C. Dunfee  
(b) Address Grant City, Mo.  
19. (a) Jan. 26 1945 (b) Wagner Leichert (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(c) Accident, suicide, or homicide (specify) no  
(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 W. H. Hays (M.D. or other)  
Address Grant City, Mo. Date signed 1-22-45

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

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**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

*Arch C. Dingle*

Licensed Embalmer No.

*3252*

P. O. Address

*Heart City, 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.**