

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13100

State File No. \_\_\_\_\_

FILED MAY 12 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5222

Registrar's No. 62

16  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Pass  
(a) County \_\_\_\_\_  
(b) City or town Rural Dolan Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2 miles S. of Freeman  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution At Home  
(Specify whether \_\_\_\_\_)  
In this community 60 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Pass  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 M. S. of Freeman Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Virginia Ellen Thomas  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 29  
year 1945 hour 6 minute 30 A.M.

4. Sex Female 5. Color of hair White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: March 18 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 2, 1945 to April 28, 1945  
that I last saw her alive on April 26, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
75 1 11 hr. min.

Immediate cause of death Cerebral Hemorrhage  
Duration \_\_\_\_\_

9. Birthplace Elizabeth Town Ky.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Invalid 60 yrs.

Other conditions (Include pregnancy within 3 months of death)  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Robert Austin Thomas  
13. Birthplace Ky.  
(City, town, or county) (State or foreign country)  
14. Maiden name Tarrell's Jones  
15. Birthplace Ky.  
(City, town, or county) (State or foreign country)

Major findings: 830  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant QA Thomas  
(b) Address Freeman, Mo.  
17. (a) Burial (b) Date thereof 5/1/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Freeman Cemetery  
18. (a) Signature of funeral director Adkinson  
(b) Address Harrisonville Mo.  
19. (a) May 1, 1945 (b) Margaret Valle  
(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) \_\_\_\_\_ (Means of injury)  
23. Signature J. W. Seiff (M. D. or other) \_\_\_\_\_  
Address Harrisonville, Mo. Date signed 5/1/45

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 *personally*

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Robert A. Kincaid*

Licensed Embalmer No. *3920*

P. O. Address *Hansonville, 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.**