. No. 2
—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 13460

Registrar's No. 360

1. PLACE OF DEATH:

(a) County GREENE

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

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

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 2323 6 Ave
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jefferson Thomas

3. (b) If veteran name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced Sep.

6. (b) Name of husband or wife unk.

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

7. Birth date of deceased Oct. (Month) 8 (Day) 1872 (Year)

8. AGE: Years	Months	Days	If less than one day
72	6	19	hr. min.

9. Birthplace Unk. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Matt Thomas
13. Birthplace Texas Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Anne McCary
15. Birthplace Unk. (City, town, or county) Unk. (State or foreign country)

16. (a) Informant Tony M. Thomas
(b) Address 506 Chicago St. Spgd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/45 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Bellevue

18. (a) Signature of funeral director J. M. Klingman etc
(b) Address Springfield Mo

19. (a) 4-28-45 (Date received local registrar) (b) Dr N. S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Apr. 24 1945 to 4-27-45 that I last saw him alive on 4-27-45 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Fracture of skull

Due to Car wreck

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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) Accident

(b) Date of occurrence 4-24-45

(c) Where did injury occur? Springfield (City or town) Greene (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place-Corner Kearney & Kellett (Specify type of place)

While at work? No (e) Means of injury Automobile

23. Signature [illegible] (M. D. or other)

Address 450 1/2 Commercial Spgd., Mo. Date signed 4/28/45

(Licensed Embalmer's Statement on Reverse Side)

MAY 19 1965

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.....

P. O. Address.....

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.

S/No. 2B
M—5-43
I X36930

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

State File No. May

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 360

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(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)

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

3. (a) PRINT FULL NAME Jefferson 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 Sep

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 8 (Day) 1872 (Year)

8. AGE: Years 72 Months 6 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) no (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 5-24-, 1945 to 5-27, 1945 that I last saw h alive on 5-27-45, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebal Hemmorage

Due to Fracture of Skull

Due to Car Wreck

Other conditions Collision with mother
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 170 °F

Duration

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) accident

(b) Date of occurrence Apr 24, 1945

(c) Where did injury occur? City (City or town) Greene (County) Mo (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

23. Signature Henry F. Knabb (M. D. or other)

Address 450 1/2 E Coml Springfield Mo Date signed 5-14-45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

13460