

FILED MAY 4 1945

Registration District No. 233

Primary Registration District No. 4348

Registrar's No. 6

70
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Wellsville Mo
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 7 years
years, months or days

3. (a) PRINT FULL NAME

William Baird Thompson

3. (b) If veteran, name war _____

3. (c) Social Security No. 1

4. Sex Male 5. Color of race W.
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Dec 26 1847
(Month) (Day) (Year)

8. AGE: Years 97 Months 3 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name Robert W. Thompson

13. Birthplace Kentucky
(City, town or county) (State or foreign country)

14. Maiden name Sarah Beard

15. Birthplace Kentucky
(City, town or county) (State or foreign country)

16. (a) Informant Quinn Berger

(b) Address Wellsville Mo

17. (a) Bury (b) Date thereof 4-23-45
(Burial, cremation) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Mo

18. (a) Signature of funeral director _____
(b) Address Wellsville Mo

19. (a) APR 26 1945 Mrs. Virginia Norton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Wellsville Mo 70
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21
year 1945 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 19
1947 to April 20, 1948
that I last saw him alive on April 20, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary occlusion
Due to Hypertension
Chronic Bronchitis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 1971
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?
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature R. G. H. H. H. (M. D. or Other)
Address Wellsville Mo Date signed 4-21-48

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-3-45

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

Signed T.B. Hulbert

Licensed Embalmer No. 1588

P. O. Address Hellaville 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.