DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 13 1945

24022

State File No.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 561

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

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: O'Reilly General Hospital 0 (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield, 2 (If outside city or town limits, write "RURAL")

(d) Street No. O'Reilly General Hospital 6 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kate Shire Thomas

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 4

6. (b) Name of husband or wife William Edwin Thomas

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

7. Birth date of deceased February (Month) 15, (Day) 1864 (Year)

8. AGE: Years 81 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Leavenworth, (City, town, or county) Kansas 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In Home

FATHER
12. Name Daniel Shire
13. Birthplace Dublin, (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Ann Matilda Geffry
15. Birthplace Akron (City, town, or county) Ohio 1 (State or foreign country)

16. (a) Informant Mrs. George B. Foster, Jr.

(b) Address Springfield, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth, Kansas

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 7-20-45 (Date received local registrar) (b) D W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19th, year 1945 hour 6:45 minute P. M.

21. I hereby certify that I attended the deceased from November, 1942, to 19 July, 1945; that I last saw her alive on 19 July, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Myocardial Infarction	5 days
Due to Generalized Arteriosclerosis	many years
Due to	
Other conditions Simple Fracture right femur (Include pregnancy within 3 months of death)	15 days

Major findings:
Of operations
Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) no 39

(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 0

23. Signature Allen J. Jones, Lt Col MC (M. D. or other) MD

Address Springfield, Mo. Date signed 20 July 1945

484

(Licensed Embalmer's Statement on Reverse Side)

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.....L. A. Roof.....

Licensed Embalmer No.....2044.....

P. O. Address.....Springfield Ore.....

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.

X

S. No. 2B
5M—3-45
I X43880

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Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 561

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 Kate S. 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 Wid

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

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

7. Birth date of deceased Oct 15 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Kansas (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 July 19
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Nov. 1942 ..... 19.., to 19 July, 1945; that I last saw h. 9 alive on 14 July, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	4 days
Due to Generalized Arteriosclerosis	—
Due to	
Other conditions Fracture Rt. Femur (Include pregnancy within 3 months of death)	12 days

Major findings:
Of operations —
Of autopsy 14 Jan 45

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) external causes accident Not duty A.P.
(b) Date of occurrence 7 July 45
(c) Where did injury occur? In hospital room (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Had been a patient in O'Reilly Gen. Hosp at time of fall (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Allen J. Cass (M. D. or other)
Address Springfield, Mo. Date signed 17 Aug 45

SUPPLEMENTARY

FILED

24022