S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28781

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 117

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural Washington Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 yr 10 mo 13 days (Specify whether years, months or days)
In this community 11 yr 10 mo 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Kan (b) County 108
(c) City or town Garland (Kans) (If outside city or town limits, write "RURAL")
(d) Street No. RFD #2 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME JOHN THOMPSON
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jennie Thompson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov 16 (Month) (Day) 1868 (Year)

8. AGE: Years 76 Months 8 Days 15 If less than one day hr. min.

9. Birthplace Logansport, Ind (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business
MOTHER FATHER
12. Name James Thompson
13. Birthplace Ind (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Jane King
15. Birthplace Ind (City, town, or county) (State or foreign country)
16. (a) Informant Papers & Patient
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-1-46 (Month) (Day) (Year)
(c) Place: burial or cremation Ft. Scott, Kans
18. (a) Signature of funeral director C. E. Griffine
(b) Address Garland, Kans
19. (a) 8-4-45 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1 year 1945 hour 4 minute 45 A.M.
21. I hereby certify that I attended the deceased from July 30, 1945 to Aug 1, 1945 that I last saw him alive on Aug 1, 1945 and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Arteriosclerosis — Duration 7
Due to
Due to
Other conditions Syphilis (Include pregnancy within 3 months of death)
Major findings: Of operations no
Of autopsy no
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 0
23. Signature R. G. Hall M.D. (M. D. or other)
Address Nevada Mo Date signed 8/1/46

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
8-45-825
9-5-45

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2030

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.