

FILED DEC 15 1945 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. 194-

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County JASPER

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

(c) Name of hospital or institution: McCune-Brooks Hospital 1)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Mo. - 2 da.  
(Specify whether years, months or days)

In this community 63 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Carthage 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 311 W. Sixth St  
(If rural, give location)

(e) Citizen of foreign country? no 1) (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Ada Thomas

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5  
year 1945 hour 6:30 minute PM M.

21. I hereby certify that I attended the deceased from 8-29-45  
1945 to 8 Nov 5 1945  
that I last saw her alive on Nov 5 1945  
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife Wm. C. Thomas

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

7. Birth date of deceased JULY 9 - 1861  
(Month) (Day) (Year)

Immediate cause of death fracture left hip - Cerebral hemorrhage 2 Mo + 1 wk +

Due to Senility Arteriosclerosis

Due to \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>2</u>	<u>24</u>	hr. _____ min.

9. Birthplace unknown Wisconsin  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name George Roberts

13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Helen Parks

(b) Address 311 W. 6th - Carthage

17. (a) Burial (b) Date thereof Nov 7 - 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage Mo

19. (a) 11-6-45 (b) D. B. Clinton M.D.  
(Date received local registrar) (Registrar's signature)

Other conditions \_\_\_\_\_  
(Includes pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of work)  
(c) Means of injury \_\_\_\_\_

23. Signature D. Russell Smith (M. D. or other) M.D.  
Address Carthage, Mo. Date signed 11-6-45

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

45-11-95 H.

**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..... *Emma R. Guel*

Licensed Embalmer No: *391*

P. O. Address..... *Carthage*

**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.**

Registration District No. 157 Primary Registration District No. 3028

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

1. PLACE OF DEATH:  
(a) County Jasper Carthage  
(b) City or town Jasper Carthage  
(If outside city or town limits, write "RURAL" and name of town)  
(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  
3. (a) PRINT FULL NAME Ada Thomas  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 \_\_\_\_\_  
7. Birth date of deceased July 9 1862  
(Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug Day 28 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to fracture left hip

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 1862/18

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence August 28, 1945  
(c) Where did injury occur? Carthage Jasper Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Fall

23. Signature W Russell Smith (M. D. or other) MD

Address Carthage Mo Date signed 12-19-45

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

W. L. RAY

37649

Chicago, Ill.

No. 10

W. L. RAY