

FILED APR 29 1946

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1533

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town St. Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
15 West 6th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community do not know (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town St. Joseph Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 15 West 6th St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Joe Thompson

3. (b) If veteran, name war _____
3. (c) Social Security name war no 4696-09-1820

4. Male 5. Color or White
6. (a) Single, widowed, married, Married

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

7. Birth date of deceased Sept 5 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____
If less than one day hr. _____ min. _____

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant Walter A Thompson
(b) Address St Joseph Mo

17. (a) Burial (b) Date thereof 4/11/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation West Hope B.C. 131

18. (a) Signature of funeral director Parsons Bros
(b) Address St Joseph Mo

19. (a) 3-30-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1946 hour 12 minute 0 M.

21. I hereby certify that I attended the deceased from March 19____, 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 Coronary Insufficiency
Due to arteriosclerosis

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

Major findings: Of operations no

Of autopsy no
Hunting & Ingvaldsen

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 place)
(e) Means of injury fall

23. Signature James M. Walker (M.D. or other)
Date signed 3-30-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. S. Walton

Licensed Embalmer No. 2744

P. O. Address K. C. 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.