

S. No. 2  
M-5-43  
v. 5-17-39  
P I X36671

99726

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1379

Registration District No. 149

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days  
(Specify whether years, months or days)

In this community 42 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 325 No Lawn  
(If rural, give location)

(e) Citizen of foreign country? XXXX (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gerald R. Thomson

3. (b) If veteran, name war World War I

3. (c) Social Security No. 702-14-9777

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 20  
year 1946 hour 1 minute 30 P. M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Lillian H. Thomson

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased 8/14/1894  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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

8. AGE:	Years	Months	Days	If less than one day
<u>Dublin</u>	<u>51</u>	<u>7</u>	<u>6</u>	hr. _____ min.

Due to Dissecting aneurysm of the aorta -

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

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

10. Usual occupation Sheet Metal Worker

11. Industry or business M. O. P. Ry

12. Name Joseph Thomson

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

14. Maiden name Julia Walsh

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 months of death)

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

Of autopsy See Above.

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

16. (a) Informant Lillian H. Thomson

(b) Address 325 No Lawn

17. (a) Burial (b) Date thereof 3/23/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director John P. Sheil  
(b) Address R. C. Mo.

19. (a) 3-22-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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)  
\_\_\_\_\_ (Specify type of means of injury)

23. Signature A. E. Weber (M. D. or other)  
Address 2800 Main Date 3/20/46

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

3052

861

APR 5 1946

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**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.....

*John P. Shield*

Licensed Embalmer No. ....

*3625*

P. O. Address.....

*76 E. 40.*

**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.**