

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26711

State File No.

FILED AUG 27 1946

Registration District No. 96 Primary Registration District No. 4158 Registrar's No. 54

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Buffalo
(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 life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas ³⁰

(c) City or town Buffalo ⁰
(If outside city or town limits, write "RURAL") ⁰

(d) Street No. _____ (If rural, give location) ⁰

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

If yes, name country _____

3. (a) PRINT FULL NAME LEONA THOMSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Color or white

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

6. (b) Name of husband or wife Walter

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased June 14 1896
(Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation housekeeper

11. Industry or business _____

MOTHER FATHER

12. Name William Cranch

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

14. Maiden name Anne German

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

16. (a) Informant Walter Thomson

(b) Address Buffalo Mo

17. (a) Burial, cremation, or removal Burial Date thereof 7-17-46
(Month) (Day) (Year)

(c) Place: burial or cremation Long Rock

18. (a) Signature of funeral director H B Jones

(b) Address Buffalo Mo

19. (a) Aug 18, 1946 (Registrar's signature) Grace Petter
(Date received local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1946 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 6 1946 to July 16 1946
that I last saw her alive on July 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis inferior vena cava 11 days

Due to Carcinoma of uterus 1 year

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 18/8

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 place) (e) Means of injury 0

23. Signature O. Griffin M.D. (M. D. or other)

Address Buffalo Mo. Date signed 7-18-46

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

RECEIVED
DISTRICT No. 70
Dist. No. 7-46-822
Date Filed 8-23-46

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 Maria B. Jones
Licensed Embalmer No. 432a
P. O. Address Buffalo, 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.

Registration District No. 96 Primary Registration District No. 4158

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Buffalo
(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

3. (a) PRINT FULL NAME Lena Thomson
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 m

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

7. Birth date of deceased June 14 1906
(Month) (Day) (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (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) Aug 18 1946 (b) Ernie Petree
(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 CERTIFICATE
20. DATE OF DEATH, Month Aug year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alone on _____, 19____; and that death occurred on the date and hour stated above, immediate cause of death _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____

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 _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

26711