

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
6 1946 THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32930

State File No. \_\_\_\_\_  
Registrar's No. 55

Registration District No. 85 Primary Registration District No. 40815216

1. PLACE OF DEATH:

(a) County Carter  
 (b) City or town Pleasant (General)  
 (If outside city or town limits, write "RURAL" and name of township)  
his own home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Carter  
 (c) City or town Pleasant (General)  
 (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Grant Thomas  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14  
 year 1946 hour 12 minute 11 P.M.  
 21. I hereby certify that I attended the deceased from June 1946  
 that I last saw him alive on \_\_\_\_\_ 1946  
 and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If \_\_\_\_\_

Immediate cause of death: acute circulatory failure  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

7. Birth date of deceased Sept 17 1945  
 (Month) (Day) (Year)  
 8. AGE: Years 73 Months 0 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: 162  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Ohio  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation farmer

11. Industry or business \_\_\_\_\_  
 12. Name Julia Thomas  
 13. Birthplace Ohio  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Thomas  
 15. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Ed Dixon  
 (b) Address W. 11th St. Pleasant  
 17. (a) buried (b) Date thereof 1-15-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Rock Creek Cemetery  
 18. (a) Signature of funeral director W. J. Ross  
 (b) Address W. 11th St. Pleasant  
 19. (a) Oct. 22-46 Mrs. Octa Hewson  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature Frank Kucinski (M. D. or other) Dr.  
 Address Van Buren MO Date signed 10-22-46

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

31818

RECEIVED

District Health Officer No. 5,

District File Number 1046286

Date Filed 11-4-46

Body was not embalmed  
no undertaker

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.....

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.