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17-39  
47070

**FILED JAN 14 1947**  
Registration District No. **75**

Primary Registration District No. **3015**

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

**1. PLACE OF DEATH:**  
(a) County Cleaton  
(b) City or town Cameron  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
708 W. 3rd St 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Lifetime years, months or days

**3. (a) PRINT FULL NAME** Fred E. Thompson  
**3. (b) If veteran,** name war No.  
**3. (c) Social Security** No. NO.

**4. Sex** Male **5. Color or race** white  
**6. (a) Single, widowed, married, divorced** married  
**6. (b) Name of husband or wife** Ella Thompson  
**6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** June 21 1858  
(Month) (Day) (Year)

**8. AGE:** Years 88 Months 6 Days 5  
If less than one day hr. \_\_\_\_\_ min.

**9. Birthplace** No record N.Y.  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Retired Blacksmith

MOTHER-FATHER

**11. Industry or business**  
**12. Name** Delos Thompson  
**13. Birthplace** Evans (Erie Co.) N.Y.  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Harriett Cava  
**15. Birthplace** Plainfield N.Y.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** C. D. Thompson  
**(b) Address** Kansas City Mo.

**17. (a) Burial** Burial **(b) Date thereof** 12-27-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Osburn

**18. (a) Signature of funeral director** Poland Funeral Home  
**(b) Address** Cameron

**19. (a)** 12-27-46 **(b)** Mrs. Willie Jones  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Cleaton 25  
(c) City or town Cameron  
(If outside city or town limits, write "RURAL")  
(d) Street No. 708 W. 3rd St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Dec day 25  
year 1946 hour \_\_\_\_\_ minute 4:00 M.

**21. I hereby certify that I attended the deceased from** Sept 20, 1946, to Dec 25, 1946  
that I last saw him alive on Dec 24, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo. Carditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death) 93D

**PHYSICIAN**  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 circumstances)  
(c) Means of injury \_\_\_\_\_  
**23. Signature** M. Peters (M. D. or other)  
**Address** Cameron Mo. **Date signed** \_\_\_\_\_

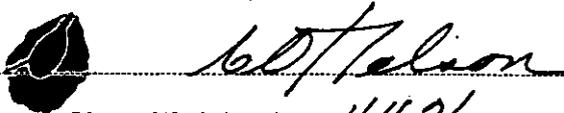
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IS. 02  
24-6-1  
1822 X 1

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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. 4421  
P. O. Address Cameron, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registrar's No. *96*Registration District No. *75*Primary Registration District No. *3015*

## 1. PLACE OF DEATH:

(a) County *Clinton*(b) City or town *Cameron*

(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 days3. (a) PRINT FULL NAME *Fred E. Thompson*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex *m*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 2*

(Month)

(Day)

(Year)

8. AGE:

Years *88*Months *6*

Days

If less than one day

hr. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) *N.Y.*

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) *12-27-46*

(Date received local registrar)

(b) *Mrs. William J. Lamb*

(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 *Dec* Day *5*  
Year *1946* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

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

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include 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 place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

39987