

FILED JUL 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24738

Registration District No. 187

Primary Registration District No. 3038

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Brookfield Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hrs.
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME ANNA MAE THOMPSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

(b) Name of husband or wife _____ (c) Name of husband or wife if _____

7. Birth date of deceased July 15 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 7 If less than one day 7 hr. 15 min.

9. Birthplace Brookfield, Linn Co, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Dr. Lee E. Thompson

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

14. Maiden name Belle Mae Searstrough

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

16. (a) Informant Dr. Lee E. Thompson

(b) Address Laclede, Mo.

17. (a) Burial (b) Date thereof July 16, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo., Cem.

18. (a) Signature of funeral director W. B. Smith

(b) Address Laclede, Mo.

19. (a) 7-16-47 (b) Walter B. Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Laclede 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1947 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from 7-15 1947 to 7-15 1947

that I last saw her alive on 7-15 1947
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis Duration 5 hrs.

Due to Premature

Due to _____

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

Major findings: Of operations 159

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 2

23. Signature W. B. Smith (M. D. or other) 2

Address Brookfield Mo Date signed 7/16

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE
Camden, N.J.

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 me

W. S. Thamm

, Registered Apprentice No.

working under my personal supervision.

Signed W. S. Thamm

Licensed Embalmer No. 2876

P. O. Address Lalude, 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.