FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 23 1947

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26426

Primary Registration District No. 3072

Registrar's No. 140

97 1 2

1. PLACE OF DEATH:
(a) County: SALINE
(b) City or town: MARSHALL, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: LITSGIVENS Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 8 DAYS (Specify whether
In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: SALINE 97
(c) City or town: SWEET SPRINGS. Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No.: South SPRING ST 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: MATHEW THOMAS
3. (b) If veteran, name war: —
3. (c) Social Security No.: —

4. Sex: MALE 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: ADA THOMAS
6. (c) Age of husband or wife if alive: 79 years
7. Birth date of deceased: FEB (Month) 26 (Day) 1876 (Year)

8. AGE: Years 71 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace: (City, town, or county) W. VA. (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business: TILLER of Soil
12. Name: B. P. THOMAS (FATHER)
13. Birthplace: (City, town, or county) W. VA. (State or foreign country)
14. Maiden name: MARTHA SPURLOCK (MOTHER)
15. Birthplace: (City, town, or county) W. VA. (State or foreign country)
16. (a) Informant: Mrs. Rene Trent
(b) Address: Sweet Springs, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/30/47 (Month) (Day) (Year)
(c) Place: burial or cremation: FAIRVIEW CEMETERY
18. (a) Signature of funeral director: R. C. Carter
(b) Address: Sweet Springs Mo
19. (a) July 1-1947 (Date received local registrar) (b) Gilbert T. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 27th year 1947 hour 4 minute 10 p M.

21. I hereby certify that I attended the deceased from April 1946, to June 27 1947 that I last saw him alive on June 24 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: James A. Reed M.D. (M. D. or other)
Address: Marshall Mo Date signed 6-30-47

REED.

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8

District File Number

Date Filed 8-2-47

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 W C Carter

Licensed Embalmer No. 3573

P. O. Address Sweet Springs 2

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.