

S. No. 2
DOM-5-43
Rev. 5-17-39
I X38671

State File No. _____

FILED NOV 13 1947

Primary Registration District No. 5135

Registrar's No. 382

1. PLACE OF DEATH:

(a) County: Butler

(b) City or town: Dublin Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home Ash Hill Tw
(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 (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME: "No. Name" Tompkins

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

4. Sex: Female 5. Color or race: White

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

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

7. Birth date of deceased: Oct - 22 - 47
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>17</u> hr. _____ min.

9. Birthplace: Dublin "Rural" Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Baby

11. Industry or business: _____

MOTHER FATHER

12. Name: Jessie Tompkins

13. Birthplace: Campbell Mo.
(City, town, or county) (State or foreign country)

14. Maiden name: Lorene Smith

15. Birthplace: Campbell Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Lorene Tompkins

(b) Address: Dublin Mo.

17. (a) Burial (b) Date thereof: Oct-23-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Dublin County

18. (a) Signature of funeral director: Friends

(b) Address: Dublin Mo.

19. (a) 11-4-47 (b) R Tompkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Butler

(c) City or town: Dublin Rural
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year 1947 hour 6 minute 2 P.M.

21. I hereby certify that I attended the deceased from Oct 22, 1947 to Oct 23, 1947
that I last saw h_____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Premature 6 1/2 mo
Hemogages in Matern.

Due to _____

Due to _____

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

Major findings: _____

Of operations: 159

Of autopsy: X

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)

(a) Means of injury: _____

23. Signature: S. Callet (M. D. or other) Mo.

Address: 114 Allen Mo Date signed: Oct 23/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

2
0
0

RECEIVED

District Health Office No. 2,

District File Number 1142-1451

Date Filed 11-11-47

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.....

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.