

FILED NOV 26 1947

Registration District No. _____

Primary Registration District No. 4123

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Wayland
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME ELIZABETH Mrs George S. Thompson
3. (b) If veteran, name war *
3. (c) Social Security No. _____

4. Sex F.M. 5. Color or race W
6. (a) Single, widowed, married, divorced 2 widowed
6. (b) Name of husband or wife Geo. S. Thompson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 27 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 0 10 hr. min.

9. Birthplace Warsaw, Ill
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business *

MOTHER FATHER
12. Name Leonard Egley
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Kathryn Staff
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Thompson
(b) Address Indianapolis Ind.

17. (a) Burial (b) Date thereof Nov. 10 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frazer

18. (a) Signature of funeral director H. Fischer
(b) Address Wayland, Mo.

19. (a) 11-15-47 (b) J. Bridges
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clark 23
(c) City or town Wayland
(If outside city or town limits, write "RURAL") 0
(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 NOV. day 7
year 1947 hour 8:45 P. minute _____ M.
21. I hereby certify that I attended the deceased from 10-20-47
_____ 19____ to 11-7- 1947
that I last saw h. alive on 11-7- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
CEREBRAL HEMORRHAGE
HEART FAILURE

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 83A
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 _____
23. Signature H. K. Hanning (M. D. or other)
Address Wayland Mo. Date signed 11-9-47

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 10
District File Number 11:47:160
Date Filed NOV 24 1947

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..... *H. F. Kischer*

Licensed Embalmer No. *2611*

P. O. Address..... *Wayland*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 37423Registration District No. 70Primary Registration District No. 4123Registrar's No. 42

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Wayland
(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 days

3. (a) PRINT FULL NAME OF

Elizabeth Thompson

3. (b) If veteran, name war _____

3. (c) Social security No. _____

4. Sex F5. Color or race W6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

(If less than one day)

80

hr.

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

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) _____

(Date received local registrar's certificate)

J. P. Bridger

(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 _____
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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.

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(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

