

FILED JAN 6 1948

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Maple Lake
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 49 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray 89
(c) City or town Richmond 1
(If outside city or town limits, write "RURAL")
(d) Street No. Maple Lake 1
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Pauline (N) THOMPSON

3. (b) If veteran,

name war None

3. (c) Social Security

No. _____

4. Sex

Female

5. Color or race

White

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

Married

6. (b) Name of husband or wife

William B. Thompson

6. (c) Age of husband or wife if

alive 46 years

7. Birth date of deceased

July 5 1898
(Month) (Day) (Year)

8. AGE:

Years 49 Months 7 Days 11
If less than one day hr. min.

9. Birthplace

Richmond Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

housewife

12. Name

Ollie Lytle

13. Birthplace

Mo.
(City, town, or county) (State or foreign country)

14. Maiden name

Mattie Owen

15. Birthplace

Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant

William B. Thompson

(b) Address

Richmond, Mo.

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof. 12/21/47
(Month) (Day) (Year)

(c) Place: burial or cremation

Summit - Richmond

18. (a) Signature of funeral director

Frank L. H. K.

(b) Address

Richmond, Mo. per Griffith

19. (a)

Dec 22 1947
(Date received local registrar)

(b) Mabel Jackson
(Registrar's signature) 297

MOTHER FATHER

MOTHER FATHER

20. DATE OF DEATH: Month Dec day 18

year 1947 hour 10:45 minute P. M.

21. I hereby certify that I attended the deceased from

1-6-47, 19, to 12-18-47, 19

that I last saw R alive on 12-18-47, 19

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

Immediate cause of death

Intestinal hemorrhage

Duration

2 days

Due to Abdominal Sarcoma ✓

2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

ADDITIONAL PHYSICIAN SUPPLEMENTAL INFORMATION REQUESTED

PHYSICIAN I decline to certify death unless death could 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

Sh. J. Love

(M. D. or R. N.)

Address Richmond, Mo.

Date signed 12-20-47

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-2-48

KEY

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 *George H. White*

Licensed Embalmer No. 4066

P. O. Address *Richmond, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registrar's No. *119*Registration District No. *297*Primary Registration District No. *3057*

1. PLACE OF DEATH:

- (a) County *Ray*
 (b) City or town *Richmond*
 (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 *Pauline n. Thompson*

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex
- F*
5. Color or
- B*
- race.....
-
6. (a) Single, widowed, married,
-
- divorced.....

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
-
- 49*
-hr. min.

9. Birthplace.....
-
- (City, town, or county) (State or foreign country)
- No*

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)..... (b) (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
- April*
- 18
-
- 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
- Colon*
-

- Other conditions.....
-
- (Include pregnancy within 3 months of death)

- Major findings:
-
- Of operations.....

- Of autopsy.....
- H6E*

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

42703