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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32632  
Registrar's No. 928

FILED NOV 1 1948  
Registration District No. 28

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
O'Reilly VA Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In-hospital or institution 53 days (Specify whether  
In this community 53 days years, months or days)

3. (a) PRINT FULL NAME Guss Thompson

3. (b) If veteran, name war VW I 3. (c) Social Security No. Unknown

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mayetta Thompson 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased May 9 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 5 16 hr. min.

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

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Hospital Records

(b) Address O'Reilly VAH Springfield, Mo.

17. (a) Removal (b) Date thereof 10/27/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Kansas

18. (a) Signature of funeral director Gorman-Scharpf Funeral Home  
Springfield, Missouri

(b) Address Springfield, Missouri

19. (a) 10-26-48 (b) W.L. Landry MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2041 No. 3d St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25  
year 1948 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from  
September 2, 1948, to October 25, 1948,  
that I last saw him alive on October 25, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Pulmonary Cavitation extensive right Duration

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 13/B

Of autopsy Same as above

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?

(Specify type of place) (e) Means of injury 0

23. Signature A.J. Bordurian (M.D. 10000)

Address Actg Clinical Director VA Hospital, Springfield, Mo

**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

*Gene C. Hunter*

, Registered Apprentice No.

*291*

working under my personal supervision.

Signed

*L. D. Gorman*

Licensed Embalmer No.

*3177*

P. O. Address

*Springfield, 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.**