

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant City
(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 years, months or days)
In this community 25 years

3. (a) PRINT FULL NAME Mary Jane Thomas

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 widowed
6. (b) Name of husband or wife John P. Thomas 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 1, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 2 21 _____ hr. _____ min.

9. Birthplace Afton (rural) Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Josiah Conkle
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Sarah Rex
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant John Conkle
(b) Address Grant City, Mo.
17. (a) Burial (b) Date thereof 10-24-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fletcher Cemetery

18. (a) Signature of funeral director A. C. [Signature]
(b) Address Grant City, Mo.
19. (a) Disobey 18-1948 (b) John E. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Grant City
(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 22
year 1948 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on Oct 22, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Mesenteric vessels Duration 2 days
Due to Strangulated Hernia 6 days
Due to _____

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

Major findings: _____
Of operations _____
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Frank B. [Signature]
Address Grant City, Mo. Date signed 10/24/48

PHYSICIAN

Underline the cause of death which should be charged statistically.

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

NOV 30 1961

DISTRICT HEALTH OFFICE
Cameron, 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 _____

_____, 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.