

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5157

State File No. 497  
Registrar's No. 497

BIRTH NO. 49-008112 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>	
c. LENGTH OF STAY (in this place) <u>10 days</u>		d. STREET ADDRESS (If rural, give location) <u>X</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fairmount Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Teckla</u> b. (Middle) <u>THOMAS</u> c. (Last) <u>THOMAS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 25, 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>X</u>	8. DATE OF BIRTH <u>JAN. 15, 1949</u>
9. AGE (In years last birthday) <u>10</u>	IF UNDER 1 YEAR Months <u>10</u>	IF UNDER 24 HRS. Days <u>10</u>	IF UNDER 12 HRS. Hours <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>X</u>		13b. MOTHER'S MAIDEN NAME <u>Margie Thomas</u>	
14. NAME OF HUSBAND OR WIFE <u>X</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X</u>	
16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Margie Thomas - Fairmount Hosp.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Chronic Upper Respiratory Infection</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
18. INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION <u>475X</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 12</u> , 19 <u>49</u> , to <u>Jan 25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>49</u> , and that death occurred at <u>9:40</u> a. m., from the causes and on the date stated above.			
23a. SIGNATURE <u>R.C. Jeffries</u>		23b. ADDRESS <u>6315 Birney Side Plaza</u>	
23c. DATE SIGNED <u>Jan 25, 1949</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Feb. 4-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	
24d. LOCATION (City, town, or county) (State) <u>Nickman Mills Mo</u>		DATE REC'D BY LOCAL REG. <u>2-2-49</u>	
REGISTRAR'S SIGNATURE <u>Deraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>X P. D. Schler</u>	
ADDRESS <u>1415 G 15</u>			

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

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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

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.