

FILED JUL 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

1939

BIRTH NO. _____		REG. DIST. NO. <u>132</u>		PRIMARY REG. DIST. NO. <u>7203</u>		Registrar's No. <u>55</u>	
1. PLACE OF DEATH a. COUNTY <u>Grundy</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>			
b. CITY OR TOWN <u>Galt Liberty</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY OR TOWN <u>Galt</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM THOMAS</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 22 1878</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Grundy Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James Thomas</u>		13b. MOTHER'S MAIDEN NAME <u>Kathryn Mangold</u>		14. NAME OF HUSBAND OR WIFE <u>Maudie Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give year or dates of service) _____		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Maudie Thomas</u> ADDRESS <u>Galt Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-Renal</u> ANTECEDENT CAUSES <u>Arterio-sclerotic</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>446x</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) (Min.) _____		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>1-1-1949</u> , to <u>4-22-1949</u> , that I last saw the deceased alive on <u>4-12-1949</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>J. C. Weston M.D.</u> (Degree or title)				23b. ADDRESS <u>Galt, Mo</u>		23c. DATE SIGNED <u>4-22-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-25-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Half Rock Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Grundy Mo Rural</u>		
DATE REC'D BY LOCAL REG. <u>4-25-49</u>		REGISTRAR'S SIGNATURE <u>Jene Fair</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Payne Son</u> ADDRESS <u>Galt Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 31 1953

6 1949

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 P. K. Payne Jr

Signed.....
Student Embalmer

Licensed Embalmer No. 3400

P. O. Address Salt

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.