.300
.48

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

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30619

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3635

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY, MO
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lake Side Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Cass
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Freeman
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print)
a. (First): Paula
b. (Middle): Jean
c. (Last): Thompson

4. DATE OF DEATH (Month) (Day) (Year): Aug 22 49

5. SEX: Girl
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): newborn married
8. DATE OF BIRTH: Aug. 22, 1949
9. AGE (In years last birthday): IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kansas City, Mo
12. CITIZEN OF WHAT COUNTRY?: U. S.

13a. FATHER'S NAME: Earnest Thompson
13b. MOTHER'S MAIDEN NAME: Anna Mae Martin
14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Anna Thompson
ADDRESS: Freeman, Mo

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): Cholapse & Compression of Cord — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

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.

Filed D

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug. 22, 1949, *to* 8-22, 1949, *that I last saw the deceased alive on* 8-22, 1949, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul H. Green (Degree or title): Paul H. Green D.O.
23b. ADDRESS: Harrisonville, Mo
23c. DATE SIGNED: 8/22/49

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: 8-24-49
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Cass Co Mo

DATE REC'D BY LOCAL REG.: 8-23-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Geo. E. Myers
ADDRESS: Cleveland Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Geo. E. Myers

Licensed Embalmer No. 2517

P. O. Address Cleveland Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.