

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41653

State File No.

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 8040 Registrar's No. 194

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

| | | | |
|---|---|--|----|
| 1. PLACE OF DEATH a. COUNTY <u>Livingston</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u> | c. LENGTH OF STAY (in this place) township) <u>3 1/2 mos.</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheeling, Missouri</u> | 59 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>60 Cherry Street</u> | | d. STREET ADDRESS (If rural, give location) <u>60</u> | |

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|--|-------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Addie</u> b. (Middle) <u>Whitebread</u> c. (Last) <u>Tompkins</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 1, 1949</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>March 26, 1880</u> | | 9. AGE (In years last birthday) <u>69</u> if UNDER 1 YEAR Months Days if UNDER 24 Hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Wheeling, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> |

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|---|--|---|--|
| 13a. FATHER'S NAME <u>Josiah Whitebread</u> | 13b. MOTHER'S MAIDEN NAME <u>Adeline Fenster maker</u> | 14. NAME OF HUSBAND OR WIFE <u>Manford Tompkins</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NO.</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mary L. Hrell; Wheeling, Missouri</u> |

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|---|---|--|---|
| 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>DIA BETES MELLITUS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> |
| | 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. | | <u>2107X</u> |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> 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) | 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 Aug, 1947, to Nov. 23, 1949, that I last saw the deceased alive on Nov. 23, 1949, and that death occurred at 12:30 a. m., from the causes and on the date stated above.

| | | |
|--|----------------------------------|---|
| 23a. SIGNATURE (Degree or title) <u>D. D. Bryan M.D.</u> | 23b. ADDRESS <u>Wheeling, Mo</u> | 23c. DATE SIGNED <u>12-1-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 24b. DATE <u>12-2-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling</u> |
| | | 24d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u> |

| | | |
|--|---|---|
| DATE REC'D BY LOCAL REG. <u>Dec 1-49</u> | REGISTRAR'S SIGNATURE <u>Frances B. Neill</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Norman Funeral Home, Chillicothe, Mo.</u> |
|--|---|---|

(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 _____

Jos. M. Gibson

Student Embalmer No. 305

working under my personal supervision.

Student

Joseph M. Gibson
Student Embalmer

Signed

Edward J. Dorman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.