

FILED MAR 31 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **7885**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **94**

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital NO 1 Fulton		d. STREET ADDRESS (If rural, give location) St. Joseph Hospital	
3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle) Edward c. (Last) Thomas	
4. DATE OF DEATH (Month) (Day) (Year) 3 20 1950			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Nov. 1918
9. AGE (In years last birthday) 31	IF UNDER 1 YEAR Months - Days -	IF UNDER 1 YEAR Hours - Mins. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Charles Edward Thomas		13b. MOTHER'S MAIDEN NAME Blanche McCray	14. NAME OF HUSBAND OR WIFE -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) D. K.		16. SOCIAL SECURITY NO. D. K.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records, Fulton, Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) _____		DUE TO (c) _____	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia-Catatonic			
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)	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 Feb. 2nd, 1950 , to Mch. 20, 1950 ; that I last saw the deceased alive on Mch 18, 1950 , and that death occurred at 4:18 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE M. J. Miller (Degree or title) M.D.		23b. ADDRESS State Hospital, Fulton, Mo.	23c. DATE SIGNED 2-20-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Mar. 22-1950	24c. NAME OF CEMETERY OR CREMATORY Hospital Grounds, Fulton	24d. LOCATION (City, town, or county) (State) Mo.
DATE REC'D BY LOCAL REG. Mar. 22-1950	REGISTRAR'S SIGNATURE Martha Lawrence	25. FUNERAL DIRECTOR'S SIGNATURE L. C. Thomas ADDRESS State Hospital, Fulton, Mo.	

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

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APR 5 1950

----- District File Number -----

District Health Officer No. 9

RECEIVED MAR 28 1950

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 _____

working under my personal supervision.

Student Embalmer No.

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.