

FILED JUN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17093

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 103

1. PLACE OF DEATH a. COUNTY Jackson Co Hospital b. CITY OR TOWN Rural Prairie c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson Co Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE mo b. COUNTY Jackson c. CITY (If outside corporate limits, write RURAL and give township) 407 S Grace 0484 d. STREET ADDRESS Independence, mo	
3. NAME OF DECEASED (Type or Print) Rosa Thompson (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) 5-29-1950	
5. SEX Female	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2	8. DATE OF BIRTH 4-30-1880
9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Hours Min.	11. BIRTHPLACE (State or foreign country) Texas County Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Wm. Featherage	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Adam S. Thompson (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Address Robert S. Thompson, Independence	
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) Cerebral hemorrhage 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.	
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 4-19-1950 to 5-29-1950, that I last saw the deceased alive on 25 May 1950, and that death occurred at 1:29 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Frank E. Trehan, M.D. (Deceased or title)		23b. ADDRESS Independence Mo	23c. DATE SIGNED 29 May 50
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 31, 1950	24c. NAME OF CEMETERY OR CREMATORY Brookings Cemetery	24d. LOCATION (City, town, or county) (State) Raytown, Mo
DATE REC'D BY LOCAL REG. MAY 30, 1950	REGISTRAR'S SIGNATURE Donald C. Emmschauer 378	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hob. Behren, Independence Mo	

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

JUN 12 1954

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

Walter C. Carson

Signed.....
Student Embalmer

Licensed Embalmer No. *4199*

P. O. Address *Independence*

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.