

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 199

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>199</u>			
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. LENGTH OF STAY (If in this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Nelson</u>		1970			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>none</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Helen</u> c. (Last) <u>Thompson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 2, 1951</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>Aug. 6, 1869</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 1 DAY Days <u>26</u>	IF UNDER 1 HR. Hours <u></u>	IF UNDER 1 MIN. Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Mo. U.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Abraham Leffler</u>			13b. MOTHER'S MAIDEN NAME <u>Lourena Potter</u>			14. NAME OF HUSBAND OR WIFE <u>- - - - -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Eugene Carter</u> ADDRESS <u>Marshall, 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchiogenic Pneumonia</u>				18 months	
				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 <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>1-62X</u>				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 <u>Jan</u> , 19 <u>51</u> , to <u>Mar-2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar-2</u> , 19 <u>51</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Robert Kennedy M.D.</u>				23b. ADDRESS <u>Marshall Mo</u>		23c. DATE SIGNED <u>11-3-51.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 4, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Nelson Mo</u>				
DATE REC'D BY LOCAL REG. <u>Nov 4-1951</u>		REGISTRAR'S SIGNATURE <u>Sidney F. Gray</u> <u>385</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Campbell-Lewis</u> ADDRESS <u>Marshall, Mo.</u>					

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

1970

RECEIVED

NOV 13 1951

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed NOV 13 1951

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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, 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.