

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 97

1. PLACE OF DEATH
 a. COUNTY Vernon 1090
 b. CITY OR TOWN Washington Leap
 c. LENGTH OF STAY (in this place) 9-5-20
 d. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp. #3

2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission)
 a. STATE MO
 b. COUNTY Newton
 c. CITY OR TOWN Neosho 0732
 d. STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED
 a. (First) Les b. (Middle) a. c. (Last) Thompson
 4. DATE OF DEATH (Month) (Day) (Year) Nov 20-1951

5. SEX MO 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Apr 20-1855 9. AGE (In years last birthday) 96. 10. IF UNDER 1 YEAR Days 7 11. IF UNDER 18 Hrs. 0 Min. 0

10a. USUAL OCCUPATION (of the kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Ireland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Pro. Thompson 13b. MOTHER'S MAIDEN NAME Rebecca Hoyle 14. NAME OF HUSBAND OR WIFE unc

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. unk 17. INFORMANT'S SIGNATURE OR NAME Hosp. Records Neosho ADDRESS unc

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, asphyxia, etc. It means the disease, injury, or complication which caused death.
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Senil. Dementia
 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 Senility
Psychosis
 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) _____ 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 Nov 19 1950 to Nov 20 1951, that I last saw the deceased alive on Nov 19 1951, and that death occurred at 9:00 a.m. from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) Dr. 23b. ADDRESS State Hosp #3 23c. DATE SIGNED 11/20/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Nov. 20 51 24c. NAME OF CEMETERY OR CREMATORY Unknown 24d. LOCATION (City, town, or county) (State) Chillicothe Missouri

DATE REC'D BY LOCAL REG. 11-21-1951 REGISTRAR'S SIGNATURE Anna E. Ferry 451 25. FUNERAL DIRECTOR'S SIGNATURE Gordon Funeral Home ADDRESS Chillicothe Mo

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

DEPARTMENT OF HEALTH OF MO.
 License No. 5 - Springfield
 ISSUED NOV 27 1951
 Est. File 11-27-51
 Date Filed 11-27-51

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.....
 Student Embalmer

Signed Allen H. Hays

Licensed Embalmer No. 1968

P. O. Address. Newada, 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.

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