

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38165**

0330
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 18 1952

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>5389</u>		Registrar's No. <u>92</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u> b. CITY OR TOWN <u>rural - Sinkin typ yr's</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u> c. CITY OR TOWN <u>rural, near Bunker,</u> d. STREET ADDRESS (If rural, give location) <u>Sinkin typ</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Henry</u> c. (Last) <u>Thompson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11/11/52</u>		5. SEX <u>male</u>		
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>8/10/80</u>		9. AGE (in years last birthday) <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>x General</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Dent Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Bill Thompson</u>		13b. MOTHER'S MAIDEN NAME <u>Tobitha Arnett</u>		14. NAME OF HUSBAND OR WIFE <u>Maude Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Maude Thompson</u> ADDRESS <u>Bunker 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute coronary Occlusion</u> ANTECEDENT CAUSES DUE TO (b) <u>None</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>	
19a. DATE OF OPERATION _____		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) <u>4201</u>			
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>X</u> , 19 <u>X</u> to <u>X</u> , 19 <u>X</u> , that I last saw the deceased alive on <u>X</u> 19 <u>X</u> , and that death occurred at <u>12.10A</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Charles J. Jones</u> (Degree or title) <u>Coroner</u>			23b. ADDRESS <u>Salem Mo</u>			23c. DATE SIGNED <u>11/12/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>11/14/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bay Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Bunker Mo</u>	
DATE REC'D BY LOCAL REG. <u>11-13-52</u>		REGISTRAR'S SIGNATURE <u>M.M. Hartman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Jones</u>		ADDRESS <u>Salem Mo</u>	

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 Carl H. Jensen

Licensed Embalmer No. 9370

P. O. Address Salina 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.