

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17160**

FILED MAY 25 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **582**

1. PLACE OF DEATH a. COUNTY <b>Buchanan 0117</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan 0117</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph 0</b>	
c. LENGTH OF STAY (In this place) <b>40 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>2636 Faraon Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Elmer</b>		b. (Middle) <b>E</b>		c. (Last) <b>Thomas</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 13, 1953</b>	
5. SEX <b>Male 0</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 14, 1893</b>	
9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR Months <b>59</b> Days _____ Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Embalmer &amp; Funeral Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral.</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Easton, Missouri.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Robert Thomas</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Schuck</b>		14. NAME OF HUSBAND OR WIFE <b>Sadie Thomas</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW #1.</b>		16. SOCIAL SECURITY NO. <b>491-09-6312</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Sadie Thomas</b>		ADDRESS <b>St. Joseph, Mo.</b>	
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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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension Arterial</b>				<b>7 days</b>	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>6 yrs.</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>331x</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) _____ m.		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 **5-13-53**, 19\_\_\_\_, to **5-13-53**, 19\_\_\_\_, that I last saw the deceased alive on **5-13-53**, 19\_\_\_\_, and that death occurred at **11:25P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W. Allison M.D.</b>		23b. ADDRESS <b>207 845 Bldg. St. Joseph, Mo.</b>		23c. DATE SIGNED <b>5-16-53</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 16, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>	
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DATE REC'D BY LOCAL REG. <b>May 20, 1953</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Meyerhoffer</b>		ADDRESS <b>St. Joseph, Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 17 1950

FEB 27 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 \_\_\_\_\_

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Student Embalmer No. \*\*\*\*

working under my personal supervision.

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Student .....  
Student Embalmer

Signed

*Raymond A. Harker*

Licensed Embalmer No. 4413 Missouri

P. O. Address St. Joseph, Missouri.

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.