

FILED NOV 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37871

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 493

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Miller	
b. CITY OR TOWN Lebanon,		c. CITY OR TOWN Iberia		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. Knox Nursing Home		e. STREET ADDRESS (If rural, give location) 0660,			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Jack	b. (Middle) D. Thompson	c. (Last)	(Month) Nov.	(Day) 4,	(Year) 1954

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1/29/1869	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafe operator	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Miller Co. Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Thompson	13b. MOTHER'S MAIDEN NAME Mary Jane	14. NAME OF HUSBAND OR WIFE unknown
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ruth Grady	ADDRESS Iberia, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		MEDICAL CERTIFICATION <i>Myocarditis & Myocardial degeneration</i>	INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4222	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)
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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?
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22. I hereby certify that I attended the deceased from 11-2-1954, to 11-4-1954, that I last saw the deceased alive on 11-4-1954, and that death occurred at 2:45 A.M. from the causes and on the date stated above.

23a. SIGNATURE R. E. Havell	(Degree or title) M.D.	23b. ADDRESS Lebanon, Mo.	23c. DATE SIGNED 11-13-54
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24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE 11/6/54	24c. NAME OF CEMETERY OR CREMATORY Iberia,	24d. LOCATION (City, town, or county) (State) Iberia, Mo. Miller Co.
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DATE REC'D BY LOCAL REG. 11-15-1954	REGISTRAR'S SIGNATURE Hella S. Gray	424	5. GENERAL DIRECTOR'S SIGNATURE Hella S. Gray	ADDRESS Iberia, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2032
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Received 11-20-54
Laclede County Health Unit
File No. 187
Date Filed 11-20-54

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.....
Signature of Student Embalmer

Signed Walter O. Nedges

Licensed Embalmer No. 426

P. O. Address Heris, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.