

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED AUG 26 1955

BIRTH NO. _____		REG. DIST. NO. <u>328</u>		PRIMARY REG. DIST. NO. <u>4492</u>		Registrar's No. <u>48</u>			
1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u>				b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ORAN</u>			c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>ORAN</u>		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 <u>ORAN</u>				No. STREET ADDRESS (If rural, give location) <u>ORAN</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>			b. (Middle) <u>ALBERT</u>		c. (Last) <u>THOMPSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 12 1955</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCTOBER 2 1869</u>		9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>ORAN MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>CHARLIE THOMPSON</u>			13b. MOTHER'S MAIDEN NAME <u>BETTY ?</u>			14. NAME OF HUSBAND OR WIFE <u>MICHIE THOMPSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MARVIN THOMPSON</u>				ADDRESS <u>FREEDOM IND.</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>CONCUSSION OF BRAIN</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>severe Blow To HEAD</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>MYOCARDOSIS, senile DEMENTIA</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>15 HRS.</u> <u>15 HRS</u> <u>10 YRS.</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</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.) <u>ON THE HIGHWAY</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>9045 MO</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8-11-55 2:30 pm</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>FELL OFF DITCH ON SIDE OF ROAD</u>					
22. I hereby certify that I attended the deceased from <u>8-11</u> , 19 <u>55</u> , to <u>8-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-11</u> , 19 <u>55</u> and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>H. J. Masbach, D.O.</u>				23b. ADDRESS <u>CHAFFEE, MO</u>				23c. DATE SIGNED <u>8-16-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 14 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OLD MORLEY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>MORLEY MO.</u>			
DATE REC'D BY LOCAL REG. <u>8-19-55</u>		REGISTRAR'S SIGNATURE <u>Mouel B. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl ...</u>		ADDRESS <u>ORAN, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED AUG 22 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 835-176

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of the certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed Earl J. Smith

Licensed Embalmer No. 367

P. O. Address Cherry St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.