

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **362**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Buchanan			
b. CITY OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 50 yrs		c. CITY OR TOWN St. Joseph			
d. FULL NAME OF HOSPITAL OR INSTITUTION 107 West Indiana Avenue		e. STREET ADDRESS (If rural, give location) 107 West Indiana Avenue					
3. NAME OF DECEASED (Type or Print) HENRY		a. (First)		b. (Middle) ALLEN			
		c. (Last) THOMAS		4. DATE OF DEATH (Month) (Day) (Year) January 3, 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married			
8. DATE OF BIRTH October 6, 1879		9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days			
11. IF UNDER 1 YEAR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Business		10b. KIND OF BUSINESS OR INDUSTRY Live Stock			
11. BIRTHPLACE (City and State or Foreign Country) Taos, Missouri		12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME Sam Thomas		13b. MOTHER'S MAIDEN NAME Emalene Moore		14. NAME OF HUSBAND OR WIFE Hazel Thomas			
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. 488-14-9398		17. INFORMANT'S SIGNATURE OR NAME Hazel Thomas, 107 W. Indiana Ave., City			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocardial degeneration ANTECEDENT CAUSES DUE TO (b) Diffuse interstitial nephritis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4222				INTERVAL BETWEEN ONSET AND DEATH 2 mos	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 Sept 16, 1955 , to Jan 2, 1956 , that I last saw the deceased alive on Jan 2, 1956 , and that death occurred at 5:45A m. , from the causes and on the date stated above.							
23a. SIGNATURE M. L. Tropp		(Degree or title) D.O.		23b. ADDRESS 208 Schneider Bldg., City			
23c. DATE SIGNED 1/6/56							
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Jan 6, 1956		24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery			
24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.							
DATE REC'D BY LOCAL REG. Jan 9, 1956		REGISTRAR'S SIGNATURE Lothar M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE Carroll Clark			
		ADDRESS St. Joseph, Mo.					

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

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..... *Earl A. Clark*

Licensed Embalmer No... *42*

P. O. Address... *St. Joseph, M*

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.