

FILED FEB 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

801

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3018</u>		Registrar's No. <u>14</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>rural-Spring Creek</u>)		c. LENGTH OF STAY (in this place) <u>--</u>		c. CITY OR TOWN <u>Salem</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>XX</u>				e. STREET ADDRESS (If rural, give location) <u>0331</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Royal</u> b. (Middle) <u>-</u> c. (Last) <u>Thompson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 8 1957</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>Oct 10 1884</u>	9. AGE (in years last birthday) <u>72</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, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>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>Joseph Thompson</u>		13b. MOTHER'S MAIDEN NAME <u>Melinda Hunter</u>		14. NAME OF HUSBAND OR WIFE <u>Maudie Pankey Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No X</u>		16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Irene Northcutt St Louis 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-4 hrs</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		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 <u>331X</u>				20. AUTOPSY? <u>0</u> 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) 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 <u>1939</u> , 19 <u>57</u> , to <u>2-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-6</u> , 19 <u>57</u> and that death occurred at <u>1:30P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Jos D. Jones</u> (Name or title) <u>DR. J</u>				23b. ADDRESS <u>Salem, Mo.</u>		23c. DATE SIGNED <u>2-2-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>2-10-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Jadwin Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Jadwin Mo</u>		
DATE REC'D BY LOCAL REG. <u>9/9/57</u>		REGISTRAR'S SIGNATURE <u>M.M. Hart MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John W. ...</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Carl H. Lyman*.....

Licensed Embalmer No. *2390*

P. O. Address *Salisbury*

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.