

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

17393

FILED JUN 5 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2289

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Pettis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN SEDALIA	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BOYERS ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) ROUTE #3	
Length of stay in 1b 15 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. Inside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First EARL Middle DELL Last THOMPSON			4. DATE OF DEATH Month Day Year May 16, 1957		
5. SEX Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Finney Virginia	
13. FATHER'S NAME Beverley J. Thompson			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Eliza Fuller			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. none			17. INFORMANT VA Hospital Official Record, K. C. Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain edema (uremia)		INTERVAL BETWEEN ONSET AND DEATH 6/10 X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bilateral chronic pyelonephritis	
	DUE TO (c) Low obstructive uropathy - benign nodular hypertrophy of prostate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from May 1, 1957 to May 16, 1957
Death occurred at 12 Noon m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE EDMOND YUNIS, M.D. <i>Edmond Yunis</i>	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 5/21/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-17-57	23c. NAME OF CEMETERY OR CREMATORY Gravard Hill Cem.	23d. LOCATION (City, town, or county) (State) Sedalia Mo.
24. FUNERAL DIRECTOR A. W. Newcome's Sons	ADDRESS 331 Brush	25. DATE RECD. BY LOCAL REG. 5-17-57	26. REGISTRAR'S SIGNATURE <i>Montell</i>

health, Welfare Public Service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 5 1957

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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

Licensed Embalmer No.

P. O. Address

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.

Doctor, coroner, etc. must use only standard nomenclature in item 18. Diseases in Part I must be causally related. Coroner cannot certify. USE ONLY BLACK INK OR RIBBON TYPEWRITER.

MEDICAL CERTIFICATION	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Edema (Uremia)</u>			INTERVAL BETWEEN ONSET AND DEATH. ?
	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Renal Amyloidosis</u>			?
	DUE TO (c) <u>Systemic Primary Amyloidosis</u>			?
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a))			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>May 1, 1957</u> to <u>May 16, 1957</u> . Death occurred at <u>12 Noon</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE EDMOND YUNIS, M.D. <i>Edmond Yunis</i> (Degree or title)	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 5/16/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 17, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ground Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCAMERS</u>	ADDRESS <u>1331 Brush Creek Blvd K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-17-57</u>	26. REGISTRAR'S SIGNATURE <u>new mitchell</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Basil V. Honey*

Licensed Embalmer No. *47*

P. O. Address *K. C. 7*

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.