

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. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All standard nomenclature in item 18.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 31 1957

STANDARD CERTIFICATE OF DEATH

34990

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 602

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Poplar Bluff TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rural Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Brandon Hosp,		Length of stay in 1b 7 Weeks	d. STREET ADDRESS 5M1 S.W. of Fisk (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Charles Clinton Thomas First Middle Last			4. DATE OF DEATH 10-16-57 Month Day Year		
5. SEX Male	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 2-17-1879		9. AGE (In years last birthday) 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer	11. BIRTHPLACE (City and state or country) Wayne County Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Thomas			14. MOTHER'S MAIDEN NAME Unknown		
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. 490-14-3178	17. INFORMANT Minnie Thomas Fisk, Mo. Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardiac hypertrophy	
	DUE TO (c) Hypertension 443X	
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 type="checkbox"/> NO <input checked="" 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 10:55 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 **9-20-57** to **10-16-57** and last saw **her** alive on **10-16-57**
Death occurred at **10:55** **P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. T. Brandon, M. D. (Degree or title)	22b. ADDRESS 1124 N. Main Poplar Bluff, Mo.	22c. DATE SIGNED 10-21-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-19-57	23c. NAME OF CEMETERY OR CREMATORY Brown Chapel	23d. LOCATION (City, town, or county) (State) Butler, Co. Mo.
24. FUNERAL DIRECTOR J. C. Fisk ADDRESS Fisk, Mo.		25. DATE RECD. BY LOCAL REG. 10/22/57	26. REGISTRAR'S SIGNATURE J. C. Fisk

(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 *Raymond L. Duffie*.....

Licensed Embalmer No. *47*

P. O. Address *Berme*

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