

1462

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 153

FILED FEB 3 1958

 Registration District No. 149 Primary Registration District No. 1007 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Swingtown</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CHILLICOTHE</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>A HOSPITAL</b>		Length of stay in 1b <b>4 days</b>	d. STREET ADDRESS <b>BOX 441</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>D.</b> Last <b>THOMAS</b>			4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 5, 1896</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Wheeling, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank Thomas</b>		13b. MOTHER'S MAIDEN NAME <b>Lulu Ricket</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>488 14 1233</b>	17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia with congestion and edema</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Congestive heart failure</b>					4241
DUE TO (c) <b>Hypertrophy and dilatation of the heart</b>					
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 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 <b>---</b> Month, Day, Year a.m. <b>---</b> p.m. <b>---</b>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING 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 <b>---</b>		COUNTY <b>---</b> STATE <b>---</b>
21. Attended the deceased from <b>January 5, 1958</b> to <b>January 8, 1958</b> Death occurred at <b>3:30</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>ROBERT FLINNER, M.D.</b> <i>Robert Flinner M.D.</i>			22b. ADDRESS <b>VA HOSPITAL, Kansas City, Missouri</b>		22c. DATE SIGNED <b>1-9-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JAN. 10. 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>---</b>		23d. LOCATION (City, town, or county) (State) - <b>WHEELING MISSOURI</b>
24. FUNERAL DIRECTOR <b>DIN. NEWCOMER'S SONS</b>		ADDRESS <b>1331 BRUSH CP. KANSAS CITY, MO</b>	25. DATE RECD. BY LOCAL REG. <b>1-10-58</b>	26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Cluster K Brown*

Licensed Embalmer No. *4931*  
P. O. Address *KE 870*

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.