

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025824

STATE FILE NUMBER

FILED JUL 25 1958

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3344

S. 300
1-57

No symptoms will be listed. No autopsies were performed. Only standard nomenclature in item 18. No symptoms will be listed. No autopsies were performed. Only standard nomenclature in item 18. No symptoms will be listed. No autopsies were performed. Only standard nomenclature in item 18.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
John H. Wheeler

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 106 West Armour		Length of stay in 1b 91 years	d. STREET ADDRESS (If outside, give location) 106 West Armour Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MRS. AMIE THOMSON			4. DATE OF DEATH Month Day Year July 6, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1866
9. AGE (In years last birthday) 92		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) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Licking County, Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Samuel S. Matthews	
13b. MOTHER'S MAIDEN NAME Irene Winter		14. NAME OF HUSBAND OR WIFE James H. Thomson (Dec.)	
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. None	17. INFORMANT Address Mrs. H. R. Raker 106 West Armour
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - bilateral			INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			491+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Cardio-vascular Disease.			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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 2-21-49 to 7-6-58 and last saw her/him alive on 7-1-58 Death occurred at 5:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John H. Wheeler</i> (Degree or title)		22b. ADDRESS M.D. 411 Nichols Road, K. C. Mo.	22c. DATE SIGNED 7-7-58.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 8, 1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Stine & McClure Und. Co., K. C., Mo.		25. DATE RECD. BY LOCAL REG. 7-7-58	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

1900 - 5 P.M.
1226

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 *Elias D. Ingle*

Licensed Embalmer No. *4817*

P. O. Address *Kansas City, Mo.*

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.