

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032239  
STATE FILE NUMBER

FILED OCT 10 1958

Registration District No. 107 Primary Registration District No. 2019 Registrar's No. 153

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>JUNKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JUNKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KENNETT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KENNETT</u> <u>03520</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>801-COLLEGE ST</u>		Length of stay in 1b <u>19 years</u>	d. STREET ADDRESS (If outside, give location) <u>801-COLLEGE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LORIS VICTOR THOMASON</u>			4. DATE OF DEATH Month Day Year <u>OCT-1-1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12-1891</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER &amp; GINNER</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR: Months <u>10</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
10a. FATHER'S NAME <u>PRYOR THOMASON</u>		10b. MOTHER'S MAIDEN NAME <u>MAGGIE MASSEY</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		12. SOCIAL SECURITY NO. <u>429-05-1051</u>	11. BIRTHPLACE (City and state or country) <u>FREMONT, MO</u>
13. FATHER'S NAME <u>PRYOR THOMASON</u>		14. NAME OF HUSBAND OR WIFE <u>EULAH GREEN THOMASON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>429-05-1051</u>	
17. INFORMANT <u>Don Thomason - Kennett, MO</u>		17. ADDRESS <u>Kennett, MO</u>	
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>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4201</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 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 _____ 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 _____ to _____ and last saw her alive on _____ Death occurred at <u>11:30</u> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joe A. Zimmerman, M.D.</u>		22b. ADDRESS <u>Kennett, Mo.</u>	22c. DATE SIGNED <u>3 Oct 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT-4-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City - Mt. View</u>	23d. LOCATION (City, town, or county) (State) <u>Mountain View, MO</u>
24. FUNERAL DIRECTOR <u>PAUL SALMON - KENNETT, MO</u>		25. DATE RECD. BY LOCAL REG. <u>10-3-1958</u>	26. REGISTRAR'S SIGNATURE <u>Carl Husband</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEPARTMENT .....  
COUNTY FILE NUMBER 1058-247

NOT 15 1898

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 *Edgar Reed Ford*

Licensed Embalmer No. 4433...

P. O. Address *Kennett*

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.