

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033730

STATE FILE NUMBER

FILED OCT 6 1958

Registration District No.

274

Primary Registration District No.

3052

Registrar's No.

376

1. PLACE OF DEATH a. COUNTY Pettis		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 Sedalia		c. CITY OR TOWN Beaman	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Nursing H.		d. STREET ADDRESS (If outside, give location) One Mile North Beaman	
3. NAME OF DECEASED (Type or print) First ERNEST Middle ROBERT Last THOMSON		4. DATE OF DEATH Month Sept. Day 28 Year 1958	
5. SEX Male	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 Sept. 23, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General	
13a. FATHER'S NAME Robert Kirtley Thomson		13b. MOTHER'S MAIDEN NAME Mary M. Plant	
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. 499-429082	
17. INFORMANT Miss Lillian Thomson, Rm 5, Sedalia, Mo		14. NAME OF HUSBAND OR WIFE Rose Thomson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anemia, Heart Disease DUE TO (b) Generalized Cerebral Sclerosis DUE TO (c) Sedentary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Anemia has about 15 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT—SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) X	
20c. TIME OF INJURY Hour 5 p.m. Month, Day, Year X		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.) X		20f. CITY, TOWN, OR LOCATION X	
21. I attended the deceased from 1945 to 9/28/58 and last saw her alive on 9/23/58 Death occurred at 5 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Wm. J. Beckner M.D.	
22b. ADDRESS Sedalia Mo		22c. DATE SIGNED 9/29/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 30, 1958	
23c. NAME OF CEMETERY OR CREMATORY Smithton		23d. LOCATION (City, town, or county) Smithton, Missouri	
24. FUNERAL DIRECTOR D. W. Heckart, Sedalia, Missouri		25. DATE RECD. BY LOCAL REG. 9-30-1958	
26. REGISTRAR'S SIGNATURE Frances Shelby			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

OCT 17 1958

8961 78 AOM

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 *Delbert L. Shaffer*

Licensed Embalmer No. *5863*

P. O. Address *Adala, 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.