

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**58-035153**  
STATE FILE NUMBER

SEP 22 1958 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 148

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Marshall</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marshall</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>Fitzgibbon Hosp.</u> Length of stay in 1b <u>20minutes</u>		d. STREET ADDRESS (If outside, give location) <u>1313 S Grant</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First THOMAS Middle PEARSON Last FRENCH 4. DATE OF DEATH Month Sept. Day 19, Year 1958

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1883</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	11. BIRTHPLACE (City and state or country) <u>(unknown) Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME William French 14. MOTHER'S MAIDEN NAME Alice Bell

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>None</u>	17. INFORMANT <u>Thomas E. French 765 S Odell</u> Address <u>Marshall</u>
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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 Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 45 min  
Atherosclerotic Heart Disease 5 yrs  
Gen. Atherosclerosis 15 yrs  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gen. Atherosclerosis - 4200

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.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>	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 Feb 67 to 19 Sept 58 and last saw him alive on 19 Sept 58. Death occurred at 11:56 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE See McOrbain (Type or print) 22b. ADDRESS Marshall, Missouri 22c. DATE SIGNED 20 Sept 58

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-22-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arrow Rock Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Arrow Rock, Missouri</u>
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24. FUNERAL DIRECTOR <u>Sweeney-Peser Funeral Home</u> ADDRESS <u>Marshall</u>	25. DATE RECD. BY LOCAL REG. <u>9-20-58</u>	26. REGISTRAR'S SIGNATURE <u>Cecil J. Reed</u>
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(Licensed Embolmer's Statement on Reverse Side)

Health, Welfare Public Service  
300 1-56  
All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....  
Licensed Embalmer No. 467

P. O. Address Marshall

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