

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039256

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 71

Primary Registration District No. 3017

Registrar's No. 97

300  
1-57  
0

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Excelsior Springs</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>Excelsior Springs Hosp.</u>		Length of stay in lb <u>16 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>6002 e 404 E. Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>THOMPSON</u> Last <u>THOMPSON</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>13,</u> Year <u>1958</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Ray County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Pryor</u>	13b. MOTHER'S MAIDEN NAME <u>Sallie Cook</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Thompson</u>
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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>Mrs. Jack Kinkead, 3711 East 47th Terrace, Kansas City, Missouri</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) <u>Ca of caecum c</u> <u>metastasis to liver and peritoneum</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 checked="" 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.)
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20c. TIME OF INJURY Hour <u>1530</u> Month, Day, Year	
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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 <u>Excelsior Springs, Mo.</u>	COUNTY <u>Clay</u>	STATE <u>Missouri</u>
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21. I attended the deceased from Sept 1952, to 13 Nov. 1958 and last saw <sup>her</sup> <sub>him</sub> alive on 13 Nov. 58  
Death occurred at 7:50 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George E. Sanders M.D.</u>	(Degree or title) <u>0</u>	22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>11-14-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-16-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lawson, Missouri</u>
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24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12/4/58</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: most use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

(Signed Embalmer's Statement on Reverse Side)



**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 *Luiddell Jarman* .....  
Licensed Embalmer No. *4589* .....  
P. O. Address *Essex Springs, 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.