

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013581

FILED MAY 13 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NUMBER 2005  
Registrar's No.

300  
-57

|   |                               |   |   |   |   |
|---|-------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Holt</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Kansas City</b>  |                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>Mound City</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Trinity Lutheran</b>   |                               | Length of stay in lb<br><b>8 days</b>   | d. STREET<br>ADDRESS  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                         |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>BERTHA</b> Middle <b>N.</b> Last <b>THOMPSON</b>   |                               |   | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>20</b> Year <b>59</b>   |   |   |
| 5. SEX<br><b>Fe</b>   | 6. COLOR OR RACE<br><b>Wh</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-27-1887</b>  |   | 9. AGE (In years<br>at birthday) <b>71</b><br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done<br>in last of working life, even if retired)<br><b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Indiana</b>            |   |
| 10c. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                               | 13a. FATHER'S NAME<br><b>No Record</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Marticia Beverlin</b>                   |   |
| 13c. NAME OF HUSBAND OR WIFE<br><b>Clyde Thompson</b>   |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |   | 16. SOCIAL SECURITY NO.<br><b>None</b>                                  |   |
| 17. INFORMANT<br><b>Imogene Burnett</b>   |                               | Address<br><b>So. Gate, Calif.</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute pulm edema - post pulm embolus</b>  |                               |   |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>30 min</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>post-operative of coronary</b>  |                               |   |   |   | <b>8 days</b>   |
| DUE TO (c) <b>bleeding duodenal ulcer</b>   |                               |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>obesity</b>   |                               |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>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.)  |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                               |   | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK                                  |   |   |
| 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 <b>4-12-59</b> to <b>4-20-59</b> and last saw her alive on <b>4-20-59</b><br>Death occurred at <b>7:25 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |   |   |
| 22a. SIGNATURE<br>(Degree or title)<br><b>Uttla Aring, MD</b>   |                               |   | 22b. ADDRESS<br><b>701 E 63 K.C., MO</b>  |   | 22c. DATE SIGNED<br><b>4-24-59</b>  |
| 23a. BURIAL CEMETERY, (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>4-22-59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Mound City, Mo.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Wagner Funeral Home, K C Mo</b>  |                               |   | 25. DATE RECD. BY LOCAL REG.<br><b>4-21-59</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Irene Minshall</b>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

F. H. Hartwig

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2:00 P.M.

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 *Alvin R. Haunschu*

Licensed Embalmer No. *415*

P. O. Address *Kansas*

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.