

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014030

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 42

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Brookfield</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>Doctors Hospital</u> Length of stay in lb <u>5 days</u>		d. STREET ADDRESS (If outside, give location) <u>713 1/2 N. Main</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u></u> Last <u>Thompson</u>			4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>
5. SEX <u>Female</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>Dec. 3, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> IF UNDER 24 MRS.: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>West Alton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Jacob T. Reiderhouser</u>		13b. MOTHER'S MAIDEN NAME <u>Angelina Thies</u>	
14. NAME OF HUSBAND OR WIFE <u>George W. Thompson (deceased)</u>		16. SOCIAL SECURITY NO. <u>none</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>		17. INFORMANT Address <u>Mrs. R. P. Sims, St. Joseph, Missouri</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>Chronic Nephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis with Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>10 mos</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a) <u>4201</u>			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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>			
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>1953</u> to <u>1959</u> and last saw her <u>alive</u> on <u>5/5/59</u> Death occurred at <u>3:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W B Ewain, D.D.</u>		22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 8-1959</u>	26. REGISTRAR'S SIGNATURE <u>W B Ewain</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAY 13 1959

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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 *Gerald I. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Browning*

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.