

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1959

59-024272

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 763 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 50 Yrs	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2737 Farleigh Terr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MIDDLE Last HARRY J. THOMPSON			4. DATE OF DEATH Month Day Year July 29 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager		10b. KIND OF BUSINESS OR INDUSTRY Wyeth Co.	11. BIRTHPLACE (City and state or country) Fairfax, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Thompson		13b. MOTHER'S MAIDEN NAME Catherine Majors		14. NAME OF HUSBAND OR WIFE Elizabeth Thompson	
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. 491-09-3382	17. INFORMANT Address Mrs H.J. Thompson 2737 Farleigh Terr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cardiac asystole</i>		<i>minutes</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Chronic cor pulmonale</i>	<i>years</i>
	DUE TO (c) <i>Pulmonary fibrosis and emphysema secondary to asthma</i>	<i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Renal insufficiency</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 Month, Day, Year a.m. p.m.	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 7/25/59 to 7/29/59 and last saw him alive on 7/29/59
Death occurred at 9:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In fee or title) <i>Caryl A. Potter M.D.</i>		22b. ADDRESS <i>Physicians & Surgeons Bldg.</i>	22c. DATE SIGNED <i>7/29/59</i>
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE 7-31-59	23c. NAME OF CEMETERY OR CREMATORY <i>St. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>
24. FUNERAL DIRECTOR <i>H.S. Schumaker & Son R.R. 4,</i>	ADDRESS <i>St Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>July 30, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Standell</i>

DOCUMENT

BY AFFIDAVIT OF C. A. Potter, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

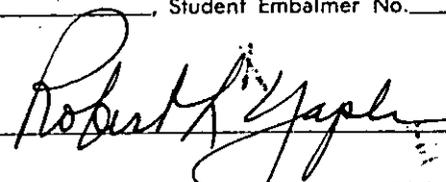
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.