

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029921

FILED VS SEP 1 1959 257

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 62

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <b>Osage</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Osage</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Crawford Township</b>		Length of stay in 1b <b>12 years</b>		c. CITY OR TOWN <b>Crawford Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chamois, Mo., RFD</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Chamois, Mo., RFD</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>Grant</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8 Oct 1867</b>	9. AGE (last birthday) <b>91</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employe</b>		11. BIRTHPLACE (City and state or country) <b>Chamois, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William H. Thompson</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Ferguson</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Loyd Matthews, Chamois, Mo., RFD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 a.m. p.m.		Month, Day, Year					
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 <b>March 1956</b> to <b>Aug 1959</b> and last saw him alive on <b>Aug 18 1959</b> Death occurred at <b>6:15</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. O. McFadyly M.D.</b>				22b. ADDRESS <b>507 East High St</b>		22c. DATE SIGNED <b>8-29-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>27 Aug 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White</b>		23d. LOCATION (City, town, or county) <b>Osage County, Mo.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Morton Funeral Home, Linn, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8/29/59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clyde Moston</b> <i>W. O. M.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *Jerome M. Weston*

Licensed Embalmer No. 4125

P. O. Address *Levin 7*

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.