

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036845

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3090 Registrar's No. 248

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--------------------------------------|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Livingston</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Caldwell</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> | | Length of stay in 1b <u>1 day</u> | | c. CITY OR TOWN <u>Breckenridge</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>Clay Street</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>none</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>ALICE</u> Last <u>THOMPSON.</u> | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>13</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>8-10-78</u> | | 9. AGE (last birthday) <u>81</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife Beauty School Graduate</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>James Knox Liggett</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Ann Ridgeway</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Nathan Thompson</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> | | | | 16. SOCIAL SECURITY NO. <u>406-22-9771</u> | | 17. INFORMANT Address <u>Nathan Thompson Inglewood, Colo.</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>Coronary Occlusion</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> | | | |
| 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) | | | | | | | | 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 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>8:30 A</u> 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 <u>None</u> on <u>Oct-13-59</u> and last saw him alive on <u>Oct-13-59</u> Death occurred at <u>8:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Joseph A. Conrad M.D.</u> (Degree or title) <u>CORONER</u> | | | | | | 22b. ADDRESS <u>Chillicothe, Mo</u> | | | 22c. DATE SIGNED <u>Oct 14-59</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>10-16-59</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u> | | 23d. LOCATION (City, town, or county) <u>Chillicothe, Mo.</u> | | | | (State) | | | |
| 24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME Chillicothe</u> | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>Oct 14/59</u> | | 26. REGISTRAR'S SIGNATURE <u>Frances B Reil</u> | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 1 1960

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 John Bolin

Licensed Embalmer No. 5035

P. O. Address Chillicothe, M

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.