

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 9 1960

383

5655

-60-002378

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 161

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon,</b>		Length of stay in 1b <b>1</b>	c. CITY OR TOWN <b>Odessa</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>202 E. Chestnut</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Albert</b> Last <b>Thompson</b>			4. DATE OF DEATH Month <b>January</b> Day <b>30</b> , Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-90</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Prince Washington Thompson</b>		13b. MOTHER'S MAIDEN NAME <b>Missouri A. Barker</b>	
14. NAME OF HUSBAND OR WIFE <b>Ola Thompson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>505-05-2416</b>	
17. INFORMANT <b>San., records, Mo. State San., Mt. Vern</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>Pulmonary hemorrhage</b> <b>Bronchogenic carcinoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL ONSET <b>Diag Nov</b>	
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>1-29-60</b> to <b>1-30-60</b> and last saw her/him alive on <b>1-29-60</b> Death occurred at <b>2:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>E. Hellweg M.D.</i>		22b. ADDRESS <b>Mo. State Sanatorium Mt. Vernon, Mo.</b>		22c. DATE SIGNED <b>2-1-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery Odessa Mo.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <i>Mar L Fossett Mt Vernon, Mo.</i>		25. DATE RECD. BY LOCAL REG. <b>2-1-60</b>		26. REGISTRAR'S SIGNATURE <i>Mar L Fossett</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 19 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 By Me Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address MWenon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.