

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

760-005531  
STATE FILE NUMBER

FILED VS. FEB 29 1960 73  
 Registration District No. \_\_\_\_\_ Primary Registration District No. 3014 Registrar's No. 2044 20

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Liberty</u>		Length of stay in 1b <u>1 yr</u>		c. CITY OR TOWN <u>Liberty</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>225 S. Suddarth</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>580 E. Mill</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>D</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>17</u> Year <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</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 31 1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____	
11. BIRTHPLACE (City and state or country) <u>Mayfield Ky</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>John A Thomas</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Himes</u>		14. NAME OF HUSBAND OR WIFE <u>Bertie Thomas</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>500-07-7815</u>		17. INFORMANT <u>Helen L. Galtton</u> Address <u>Liberty Mo.</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>Cerebral embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Metastasis (sq. cell carcinoma of mouth prim)</u>		DUE TO (c) <u>Squamous cell carcinoma of tongue &amp; left mandible - Dys.</u>		less than 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>debilitation</u>						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 <u>initial examination about 1/2 hour</u> and saw her <u>post mortem</u> Death occurred at <u>approx 12:30 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Wm. R. Morrison, D.O.</u>				22b. ADDRESS <u>10 West Kansas, Liberty Mo.</u>		22c. DATE SIGNED <u>2-18-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-20-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) (State) <u>Keamons MO.</u>	
24. FUNERAL DIRECTOR <u>Phurce - Arcew</u> ADDRESS <u>Liberty Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-19-60</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>	

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Harold G. Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, 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.