

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022182

FILED VS. JUL 5 1960

STATE FILE NUMBER

ENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 194

1. PLACE OF DEATH a. COUNTY <b>Adair</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clark</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>days</b>		c. CITY OR TOWN <b>Medill</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>K.O.H. Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ONIE</b> Middle <b>E.</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/23/81</b>	9. AGE (last birthday) <b>78</b>	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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (City and state or country) <b>Clay Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Ovington Thomas</b>			13b. MOTHER'S MAIDEN NAME <b>Eliza Morrow</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret G. Thomas (D)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>485.</b>	17. INFORMANT Address <b>Mrs. Celia Morris, Medill, Mo.</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>Cerebral thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>						<b>years</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) <b>arteriosclerotic heart disease</b>						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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20e. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE					
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20h. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21. I attended the deceased from <b>1958</b> to <b>June 20, 1960</b> and last saw him alive on <b>June 19, 1960</b> Death occurred at <b>2:10</b> <b>A</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. Lutencher D.D.</b>				22b. ADDRESS <b>Kirksville Mo.</b>		22c. DATE SIGNED <b>6-20-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>6/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kearney Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Davis &amp; Davis, Kirksville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>6-29-1960</b>	26. REGISTRAR'S SIGNATURE <b>Noris W. Ratliff</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. T. GATENSON, D.O.

**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 Robert B. Harris

Licensed Embalmer No. 4219

P. O. Address Kirkville, 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.