

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 21 1960

=60-023766

Registration District No. 287 Primary Registration District No. 3040 Registrar's No. 114

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY LIVINGSTON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY LIVINGSTON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in lb 7 days		c. CITY OR TOWN CHILLICOTHE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) SKYLINER MOTEL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BENJAMEN THOMPSON				4. DATE OF DEATH Month Day Year JUNE 18 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/4/1888	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY CHEMICAL CO.		11. BIRTHPLACE (City and state or country) MARSHALLTOWN, IA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM THOMPSON			13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE CLARA SMORAWSKI		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 479-10-0268		17. INFORMANT Skyliner Motel Mrs. W.B. Thompson Chillicothe, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Decompensation DUE TO (c) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days 6 mos 6 mos	
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.							
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 June 10-60 to June 18-60 and last saw him ^{PREVIOUS} alive on June 17-60 Death occurred at 2:00 P on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Joseph A. Conrad M.D.				22b. ADDRESS Chillicothe, Mo.		22c. DATE SIGNED June 18-60	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) BURIAL		23b. DATE 6/20/60	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION (City, town, or county) (State) Marshalltown, Iowa		
24. FUNERAL DIRECTOR ADDRESS NORMAN FUNERAL HOME: Chillicothe, Mo. 6/18/60				25. DATE RECD. BY LOCAL REG. 6/18/60		26. REGISTRAR'S SIGNATURE Francis B. Neill	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 29 1961

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 P. Rodgers
Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, M

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.