

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029995

FILED VS SEP 14 1960

STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 99

ENDED

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>	Length of stay in 1b <b>4hrs.</b>	c. CITY OR TOWN <b>Lathrop</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Comm.Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D.#1</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MELVIN CLIFTON THOMSON</b>			4. DATE OF DEATH Month Day Year <b>Sept. 4, 1960</b>			
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5. SEX <b>M</b>	6. COLOR OR RACE <b>Cauc.</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>12-15-1901</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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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>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Ray Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Allen Thomson</b>	13b. MOTHER'S MAIDEN NAME <b>Myrta Childress</b>	14. NAME OF HUSBAND OR WIFE <b>Reba V. Thomson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>500-07-3959</b>	17. INFORMANT Address <b>Reba Thomson, Lathrop, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
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	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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
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21. I attended the deceased from 1957 to 1960 and last saw her/him alive on Sept 4, 1960  
Death occurred at 11 AM. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>[Signature]</i>	22b. ADDRESS <b>M.D. Cameron, Mo.</b>	22c. DATE SIGNED <b>9-6-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-7-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lawson</b>	23d. LOCATION (City, town, or county) (State) <b>Lawson, Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Poland Funeral Home, Cameron, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Sept 6 1960</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Laurence J. Thompson*

Licensed Embalmer No. 4735

P. O. Address Cameron

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.