

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 16 1960

-60-030352

Registration District No. 129 Primary Registration District No. _____ Registrar's No. 48 STATE FILE NUMBER

| | | | | | | |
|---|----------------------------------|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Holt | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Holt | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mound City | | Length of stay in 1b 84 yrs. | | c. CITY OR TOWN Mound City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Duncan Nursing Home | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Harriet Middle Hays Last Thomas | | | 4. DATE OF DEATH Month Aug. Day 5 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 26, 1870 | 9. AGE (last birthday) 90 | 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) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Hillsboro, Ohio | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Scott Patton | | 13b. MOTHER'S MAIDEN NAME Mary Newby | | 14. NAME OF HUSBAND OR WIFE Hazard P. Thomas | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Floyd Porter, Mound City, Mo. | | |

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|--|---|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | DUE TO (b) Cerebral arteriosclerosis years. | |
| | | | | DUE TO (c) Generalized arteriosclerosis years. | |
| 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 checked="" 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 July 5, 1960 to Aug 5, 1960 and last saw her alive on Aug 5, 1960 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE James Humphreys M.D. (Degree or title) | | 22b. ADDRESS MOUND CITY, MO | | 22c. DATE SIGNED Aug. 9, 1960 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/7/60 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope | |
| 23d. LOCATION (City, town, or county) Mound City, Mo. | | 23e. DATE RECD. BY LOCAL REG. 8/9/60 | | 23f. REGISTRAR'S SIGNATURE Mejane Porter <i>deputy</i> | |
| 24. FUNERAL DIRECTOR James H. Crawford, Mound City, Mo. | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | |

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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.