

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041241

FILED VS DEC 12 1960

47

Primary Registration District No. 3008

Registrar's No. 323

STATE FILE NUMBER

INDEXED

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Callaway</b>                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Callaway</b> |                                                                   |                                                                                                                                                                      |                                              |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Fulton</b>                                                                                                                                                |                                                                                                           | Length of stay in 1b<br><b>5yrs.</b>                                                                                                                        |                                                                                      | c. CITY OR TOWN <b>Fulton</b>                                                                                                          |                                                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                 |                                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>200 Court St.</b>                                                                                                                               |                                                                                                           |                                                                                                                                                             | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>200 Court</b>                                                                      |                                                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                |                                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hiram</b> Middle <b>Ernest</b> Last <b>Thomas</b>                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                      | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>2</b> Year <b>1960</b>                                                                    |                                                                   |                                                                                                                                                                      |                                              |
| 5. SEX <b>M.</b>                                                                                                                                                                                                                  | 6. COLOR OR RACE <b>W.</b>                                                                                | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                                      | 8. DATE OF BIRTH <b>11-17-1873</b>                                                                                                     | 9. AGE (last birthday) <b>87</b>                                  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>15</b>                                                                                                                    | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                     |                                                                                                           |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Laborer</b>                                  |                                                                                                                                        | 11. BIRTHPLACE (City and state or country)<br><b>Callaway Co.</b> |                                                                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
| 13a. FATHER'S NAME<br><b>Benjamin F. Thomas</b>                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><b>Virginia Callerath</b>                               |                                                                                                                                        | 14. NAME OF HUSBAND OR WIFE<br><b>Edna Edwards Thomas</b>         |                                                                                                                                                                      |                                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                             |                                                                                                           |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>493-03-2477</b>                                        | 17. INFORMANT Address<br><b>Mrs Edna Thomas Fulton Mo.</b>                                                                             |                                                                   |                                                                                                                                                                      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b>                                                                          |                                                                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                                        |                                                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>                                                                                                                   |                                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:<br>DUE TO (b) _____<br>DUE TO (c) _____                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                                        |                                                                   |                                                                                                                                                                      |                                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Generalized Arteriosclerosis</b>                                                          |                                                                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                                        |                                                                   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                              |
| 19. WAS AUTOPSY PERFORMED?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <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.)                                                                |                                                                                      |                                                                                                                                        |                                                                   |                                                                                                                                                                      |                                              |
| 20c. TIME OF INJURY<br>Hour <b></b> a.m. <b></b> p.m. <b></b>                                                                                                                                                                     |                                                                                                           | Month, Day, Year <b></b>                                                                                                                                    |                                                                                      |                                                                                                                                        |                                                                   |                                                                                                                                                                      |                                              |
| 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 <b>10-1-56</b> to <b>12-2-60</b> and last saw him alive on <b>12-2-60</b><br>Death occurred at <b>1:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                                        |                                                                   |                                                                                                                                                                      |                                              |
| 22a. SIGNATURE (Degree or title)<br><b>James E. Hill MD</b>                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                                      | 22b. ADDRESS<br><b>Fulton, Mo</b>                                                                                                      |                                                                   | 22c. DATE SIGNED<br><b>12-5-60</b>                                                                                                                                   |                                              |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                         | 23b. DATE<br><b>12-4-1960</b>                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>                                                                                             |                                                                                      | 23d. LOCATION (City, town, or county) (State)<br><b>Fulton Mo/</b>                                                                     |                                                                   |                                                                                                                                                                      |                                              |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Maupin Funeral Home</b>                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><b>Dec. 5 - 1960</b>                                 | 26. REGISTRAR'S SIGNATURE<br><b>Maritta Lawrence</b>                                                                                   |                                                                   |                                                                                                                                                                      |                                              |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 27 1951

### 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

*J. J. Restore*

Licensed Embalmer No. 2555

P. O. Address Fullerton

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.