

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026133

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

FILED AUG 7 1961

Primary Registration District No. 14

Registrar's No. 147

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Ravenwood</u>			Length of stay in 1b <u>3 yrs</u>		c. CITY OR TOWN <u>Ravenwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Home</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Dillard</u> Middle <u>Jefferson</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1961</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>Ca</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-1881</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>				11. BIRTHPLACE (City and state or country) <u>Whiteville Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>unknown</u>				13b. MOTHER'S MAIDEN NAME <u>unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Mrs Sallie Thomas</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Sallie Thomas</u> address <u>Ravenwood, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Causes</u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>													
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 <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 <u> </u> Month, Day, Year <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>B. F. Byland M.D.</u> (Degree or title)						22b. ADDRESS <u>Marionville, Missouri</u>			22c. DATE SIGNED <u>7/20/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>7-28-1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>None</u>				23d. LOCATION (City, town, or county) (State) <u> </u>					
24. FUNERAL DIRECTOR <u>Atchison Funeral Home</u> <u>Marionville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-30-61</u>		26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>							

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

(Used Embalmer's Statement on Reverse Side)

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 B M Clewson

Licensed Embalmer No. 2279

P. O. Address Maryville

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.