

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028240

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 250

FILED SEP 11 1961

1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>MISSOURI</u> b. COUNTY <u>SCHUYLER</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKSVILLE,</u>		Length of stay in 1b <u>8 weeks</u>	c. CITY OR TOWN <u>GLENWOOD</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O.H. HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIE RAY THOMPSON</u>			4. DATE OF DEATH Month Day Year <u>September 6, 1961</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>11</u>	IF UNDER 24 HR Hours <u>11</u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>SCHUYLER, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ORIN THOMPSON</u>	13b. MOTHER'S MAIDEN NAME <u>CORNELIUS KETCHUM</u>	14. NAME OF HUSBAND OR WIFE <u>ELLA THOMPSON</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ELLA THOMPSON, GLENWOOD, MO.</u>
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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) <u>Acute pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial insufficiency</u>	<u>12 months</u>
	DUE TO (c) <u>Coronary occlusion</u>	<u>2 months or more</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Volvulus of Jejunum, Wound Dissuption</u>		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 checked="" 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	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 8-22-61 to 9-6-61 and last saw him alive on 9-6-61
Death occurred at 2:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dress or title) <u>James F. Hipe, D.O.</u>	22b. ADDRESS <u>Kirksville Osteopathic Hosp. 800 W. Jefferson, Kirksville, Mo.</u>	22c. DATE SIGNED <u>9-7-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9/8/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Glenwood, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Norman Funeral Home, Lancaster, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 7, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Rathoff</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

JAMES F. GIPPE, D.O.

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 James F. Gippe

Licensed Embalmer No. 4742

P. O. Address Rockwell, Mo

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.