

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044316

AMENDED

Registration District No. 128 Primary Registration District No. Food Registrar's No. 1268A STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD MO. | | Length of stay in 1b 8 DAYS | c. CITY OR TOWN ASH GROVE |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE PROTESTANT HOSP. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) EAST PART TOWN |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First JOHN Middle SMALLIN Last THOMAS | 4. DATE OF DEATH Month DEC. Day 15 Year 1961 |
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| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3 29 1878 | 9. AGE (last birthday) 83 | IF UNDER 1 YEAR Months Days | 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) INSURANCE | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | 11. BIRTHPLACE (City and state or country) WILLARD MO. | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME JAMES THOMAS | 13b. MOTHER'S MAIDEN NAME MARTHA J. WILSON | 14. NAME OF HUSBAND OR WIFE LEOTA THOMAS |
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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) NO NONE | 17. INFORMANT Address MRS J.S. THOMAS ASH GROVE 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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> | | <i>2 weeks</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>Arteriosclerotic heart disease</i> | <i>2 years</i> |
| DUE TO (c) | | |

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| 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"/> N. <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 _____ |
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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 |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 9-1-61 to 12-15-61 and last saw ^{her} _{him} alive on 12-15-61
Death occurred at 10:15 P. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>Carl R. Owen MD</i> | 22b. ADDRESS <i>600 S. Bluestone Springfield Mo</i> | 22c. DATE SIGNED <i>12-22-61</i> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 12 18 1961 | 23c. NAME OF CEMETERY OR CREMATORY Ash Grove Cemetery | 23d. LOCATION (City, town, or county) (State) ASH GROVE MO. |
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| 24. FUNERAL DIRECTOR <i>J. W. Birch</i> | ADDRESS ASE GROVE MO. | 25. DATE RECD. BY LOCAL REG. <i>12-26-61</i> | 26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i> |
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JAN 3 1962

FEB 27 1962

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 Richard E. Watts

Licensed Embalmer No. 4652

P. O. Address Ash Grove

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.