

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007448

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 14

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 18 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Lafayette</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> Length of stay in lb <u>Since 1913</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>Lafayette</u></p> <p>c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>816 South Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>THOMAS</u> Last <u>THOMAS</u></p>	<p>4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1963</u></p>
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>APR 12 1874</u></p>
<p>9. AGE (last birthday) <u>88</u></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired coal miner</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>Wales</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>Unknown</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Unknown</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>Anna Franciskato</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u></p>
<p>16. SOCIAL SECURITY NO. <u>40</u></p>	<p>17. INFORMANT Address <u>Mrs. Anna Thomas Lexington, Mo.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cardio renal vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u></p> <p style="text-align: center;">DUE TO (b) <u>Emphasema & bronchosis</u> <u>10 yrs.</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)</p> <p style="text-align: center;">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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>12-15-57</u> to <u>2-2-63</u> and last saw her/him alive on <u>2-1-63</u></p> <p>Death occurred at <u>1:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Ben H. Brasher M.D.</u></p>	<p>22b. ADDRESS <u>Lexington, Missouri</u></p>
<p>22c. DATE SIGNED <u>2-4-63</u> (State)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>2-4-63</u></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u></p>	
<p>23d. LOCATION (City, town, or county) <u>Lexington, Missouri</u></p>	
<p>24. FUNERAL DIRECTOR <u>Vaughn-Walker</u> ADDRESS <u>Lexington, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>2-4-63</u></p>
<p>26. REGISTRAR'S SIGNATURE <u>M. M. ...</u></p>	

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

VS 300 Rev. 4/59
 2542
 2542
 3
 4 0
 5 1
 6
 7 2
 8 2
 9 502.0
 10
 11
 12 2-0
 13 2-0
 USE BLACK INK OR TYPEWRITER RIBBON

SEP 25 1963

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

Paul H. Wilson

Licensed Embalmer No. 5192

P. O. Address Lexington, 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.