

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

24039

State File No. _____

No. 300
10-48

FILED JUL 20 1949

BIRTH NO. _____ REG. DIST. NO. 183 PRIMARY REG. DIST. NO. 4297 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Burdin</u> c. LENGTH OF STAY (If in this place) <u>Life</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Burdin</u> d. STREET ADDRESS (If rural, give location) <u>None</u>	
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3. NAME OF DECEASED (Type or Print) a. (First) <u>William F</u> b. (Middle) <u>Thompson</u> c. (Last) _____ 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Divorced</u> 8. DATE OF BIRTH <u>11-16-1874</u> 9. AGE (In years last birthday) <u>74</u> 10. MONTH <u>7</u> 11. DAY <u>21</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			4. DATE OF DEATH (Month) <u>July</u> (Day) <u>7</u> (Year) <u>1949</u>		
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>Agriculture</u>			11. BIRTHPLACE (State or foreign country) <u>Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>John F. Thompson</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie E. Mount</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Travis Smith, Burdin Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-vascular-renal disease</u> <u>myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-vascular-renal disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>449X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

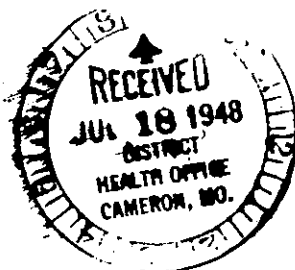
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 7/4, 1949, **to** 7/7, 1949, **that I last saw the deceased alive on** 7/7, 1949, **and that death occurred at** 7:15 A m., **from the causes and on the date stated above.**

23a. SIGNATURE (Degree or title) <u>Dr. W. L. D.</u>		23b. ADDRESS <u>Linn, Mo.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-9-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Linn, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>July 12, 1949</u>		REGISTRAR'S SIGNATURE <u>Elna Crookshank</u>	
5. FUNERAL DIRECTOR'S SIGNATURE <u>Brother Daniel Home</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



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
Student Embalmer

Signed W. R. Wright

Licensed Embalmer No. 4655

P. O. Address Leola, 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 this body is not embalmed, fact should be so stated above.