

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 24 1934

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

HOSPITAL 791

Registration District No. **1003**
Primary Registration District No.

6818
File No.
Registered No. **1672**
.....St.Ward)

2. FULL NAME

Faye Thompson
(a) Residence, No. *3233 Alfred Ave* St., *17* Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Child</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Child</i>		

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 3, 1932*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
1 8 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Child*
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo.*

13. NAME *Alfred Thompson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Marys Mo.*

15. MAIDEN NAME *Ina McDonald*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Marys Mo.*

17. INFORMANT (ADDRESS) *Alfred Thompson 3233 Alfred Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Marys Mo* DATE *Feb 17, 1934*

19. UNDERTAKER (ADDRESS) *Borchert & Borchert 2225 N. Dowling Ave*

20. FILED *Feb 18 1934* *J. Bredeck* Registrar.

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 15, 1934*
22. I HEREBY CERTIFY, That I attended deceased from *Feb 15, 1934* to *Feb 15, 1934*
I last saw him alive on *Feb 15, 1934*. Death is said to have occurred on the date stated above, at *11:15 a.m.*

The principal cause of death and related causes of importance were as follows:
Muscles 7:15 A 2-10
Bronchopneumonia

Other contributory causes of importance:
Staphylococcus Southwest
Cervical adenitis

Name of operation *Emergency Tracheotomy 2-15*
What test confirmed diagnosis? *clinical* Was there an autopsy? *Yes*

23. If death was due to external cause (violence), fill in also the following:
Accident, suicide, or homicide? *No* Date of injury....., 19.....
Where did injury occur? *No*
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....
(Signed) *John Eschenbrenner* M. D.
(Address).....

