

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECD MAR 13 1939

4831
Do not use this space.
1524

791
1003

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. 1524
 (c) City St. Louis (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Thompson

(a) Residence, No. 3305 Franklin Ave. St. 21
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ---

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4 - 9 - 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
45 10 1

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

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

FATHER 13. NAME William Thompson

14. BIRTHPLACE (CITY OR TOWN) Tennessee
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Laura James

16. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

17. INFORMANT Mrs. Willie Turner
 (ADDRESS) 1100a N. Leonard

18. BURIAL, CREMATION, OR REMOVAL PLACE Jefferson Barracks DATE 2/18, 1939

19. FUNERAL DIRECTOR (NAME) C. W. Roberts
 (ADDRESS) 3055 Lucas Ave.

20. FILED FEB 16 1939 J. B. Brudick
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/10/39 19

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on..... 19____. Death is said to have occurred on the date stated above, at 6:45 P.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy
Cardiac Hypertrophy
 Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19____
 Where did injury occur?..... (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? No
 If so, specify Joseph M. Turner, M. D.
 (Signed) Deputy Registrar
 (Address)

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.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....



Licensed Embalmer No. 1173

P. O. Address.....

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, above space should be left blank.