

1937 JUN 8 1939

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

17673
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township 1st Primary Registration District No. 1007 Registered No. 2075
 (c) City St. Louis (d) Street No. 1907 Du Sable 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 George Thompson
 (a) Residence, No. 4213 Du Sable Ave. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Print the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Loetie's Thompson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-31-1884
 7. AGE YEARS 54 MONTHS 8 DAYS 12 If LESS than 1 day,hrs. ormin.
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-17-39, 19
 22. I HEREBY CERTIFY, That I attended deceased from 5-4-39, 19, to 5-17-39, 19.
 Last saw him alive on 5-17-39, 19. Death is said to have occurred on the date stated above, at 7:40 a.m.
 The principal cause of death and related causes of importance were as follows:

Pernicious Anemia Date of onset
1076
 Other contributory causes of importance:
Broncho pneumonia

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La.
 FATHER 13. NAME Andy. Thompson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La.
 MOTHER 15. MAIDEN NAME Mary. McCallie
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss
 17. INFORMANT (ADDRESS) Record Clerk. General Hosp.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Wash DATE 5-20-39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) O. J. Meert
 20. FILED May 18 39 Dr. Dr. Brown Local Registrar.

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury
 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?
 If so, specify (Signed) J. De Maria M. D.
Sept 1907 Du Sable (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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES

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. _____

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.