

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.

NOV 13 1939 791

Registration District No. **1028**

Primary Registration District No. _____

Registrar's No. **8466**

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 9/17/39
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 1920 Papin
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Arquilla Thomas 520
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex H 5. Color or race C 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Erma Thomas 6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased Nov. 18, 1907
(Month) (Day) (Year)

8. AGE: Years 31 Months 10 Days -- If less than one day _____ hr. _____ min.

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business 1

MOTHER FATHER
12. Name Jim Thomas
13. Birthplace Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Amanda Boyd
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Evelyn Wilcox
(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 9-28-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. R. Wright
(b) Address 3500 Cutler

19. (a) OCT 3 1939
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18
year 1939 hour 1 minute 30 P. M.
21. I hereby certify that I attended the deceased from 9/17/39
_____, 19____, to 9/18/39, 19____;
that I last saw her alive on 9/18/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured gastric ulcer Duration abt 40 hours
Due to _____
Due to _____
Other conditions (Includes pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Richard C. Hestley (Physician)
Address 2601 N Whittier Date signed 9/28/39

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.