

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **34558**

Registrar's No. **9096**

Registration District No. **791**
1000

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Stillborn
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Thompson, Baby 512

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased October 7, 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Stillborn -- -- -- hr. -- min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

MOTHER FATHER { 12. Name John Thompson,

13. Birthplace ??
(City, town, or county) (State or foreign country)

14. Maiden name Glendora Dooley

15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ann Morrison

(b) Address City Hospital, #1

17. (a) Funeral Home (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director John Van Horn

(b) Address City Hospital #1

19. Oct 25 1939 (b) J. F. Brudick
(Date recorded by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County X
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 1051 Suburban Terrace,
(If rural, give location)
(e) If foreign born, how long in U. S. A. X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7,
year 1939 hour 3:05 minute A. M.

21. I hereby certify that I attended the deceased from October 7, 1939, to October 7, 1939;
that I last saw him alive on October 7, 1939;
and that death occurred on the date and hour stated above.
Immediate cause of death Stillborn

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
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 John F. Flynn (M. D. or other) 1
Address 1515 Lafayette, Date signed 10/9/39

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.