

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.

Registration District No. 13984

Primary Registration District No. 200

State File No. _____

Registrar's No. 2113

1. PLACE OF DEATH:

(a) County St. Louis Co
(b) City or town Springfield Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mother Good Council Home 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 6825 Neil Bdge Rd Specify whether
years, months or days

8. (a) PRINT FULL NAME Anne Thomas 520

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife HAN THOMAS 6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased 1-18-1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 20 If less than one day hr. _____ min. _____

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

10. Usual occupation Her work

11. Industry or business _____

MOTHER FATHER
12. Name John Calvin
13. Birthplace MARYLAND
(City, town, or county) (State or foreign country)
14. Maiden name Bessie Calvin
15. Birthplace MARYLAND
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Bessie Dupont
(b) Address 7486 N. Hazel Ave
17. (a) Buried (b) Date thereof 11/11/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Sullivan

(b) Address 7486 N. Hazel Ave

19. (a) NOV 9 1939 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PINE LAWN
(c) City or town St. Louis N.A.
(If outside city or town limits, write "RURAL")
(d) Street No. Mother Good Council Home
(If rural, give location)
(e) If foreign born, how long in U.S.A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th
year 1939 hour 12 minute 50 P. M.

21. I hereby certify that I attended the deceased from 1937
April, 19____, to Nov 8th, 19____;
that I last saw her alive on Nov 8th/1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Hypostatic Pneumonia / 48h

Due to Continued decubitus 2 mos

Due to Carcinoma Lower vertebra metastatic 3 mos

Abscess upper rt am 1 wk

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

Major findings:
Of operations carcinoma cervix 1937
date Radium Application at the _____
Of autopsy _____

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) _____ (Specify means of injury)

23. Signature M. G. Goring (M. D. or other) _____
Address 5249 Raymond Date signed 11/9/39

221 N. West 100th St
5249 Englewood

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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.....

Albert Mayfield

Registered Apprentice No.....

working under my personal supervision.

Signed *Albert Mayfield*

Licensed Embalmer No.....

3077

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.