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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9432

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2915

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hours (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County

(c) City or town Burdette NR
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JAMES FAGIN TOMPKINS

3. (b) If veteran, name war No.

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Frances

6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased Oct., 23, 1909 (Month) (Day) (Year)

8. AGE: Years 30 Months 5 Days 4 If less than one day hr. min.

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

10. Usual occupation Cotton Planter

11. Industry or business Farmer

FATHER
12. Name James Tompkins
13. Birthplace Alabama (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ruth Carlton
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tompkins
(b) Address Burdette, Arkansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-29-40 (Month) (Day) (Year)
(c) Place: burial or cremation Blytheville Ark

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) MAR 28 1940 (Date received local registrar) (b) J. F. Bradock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1940 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 27, 1940, to March 27, 1940
that I last saw him alive on March 27, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to Monocytic leukemia	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Bronchopneumonia splenomegaly, hepatomegaly, lymph node enlargement.
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature O N Anderson (M. D. or other)
Address BARNES HOSPITAL Date signed 3-27-40

(Licensed Embalmer's Statement on Reverse Side)

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 Albert H. Harper

Licensed Embalmer No. 1861

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.