

No. 2
11-10-39
3-17-39
I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16449**
Registrar's No. **3926**

Registration District No. **701** Primary Registration District No. **1003**

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:
Homer G Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
In this community **20 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: **Missouri** (b) County _____
(c) City or town **St. Louis** **18**
(If outside city or town limits, write "RURAL")
1416 Michigan
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **28**
year **1940** hour **4:30** minute _____ P. M.

4. Sex **Male** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Amelia Thomas** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 23**, 19**40**, to **April 28**, 19**40**; that I last saw him alive on **April 28**, 19**40**; and that death occurred on the date and hour stated above.

8. AGE: Years **abt 63** Months **Unknown** Days _____ If less than one day hr. _____ min. _____

Immediate cause of death **Cerebral Hemorrhage c Lt Hemiplegia** **5 das**
Duration

9. Birthplace _____ (City, town or county) **Ala. 1** (State or foreign country)
10. Usual occupation **Laborer**

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

11. Industry or business _____
MOTHER FATHER { 12. Name **Unknown** **9**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Unknown** **9**
15. Birthplace _____ (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Amelia Thomas**
(b) Address **1416 Michigan ave**
17. (a) **Burial** (b) Date thereof **May 4 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood ce**
18. (a) Signature of funeral director **H. W. Green**
(b) Address **2915 Franklin ave**
19. (a) **MAY 1 1940** (b) **J. B. [Signature]**
(Date of burial or cremation) (Funeral director's signature)

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) Means of injury _____
23. Signature **Leon Smart** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

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

4/29/40

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

W. A. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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: