

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28480**

Registration District No. **314** Primary Registration District No. **4190**

Registrar's No. **24**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) **2**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **about 40 yrs** years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St. Louis**
(c) City or town **St. Louis MO**
(If outside city or town limits, write "RURAL")
(d) Street No. **N. Alouthe Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **✓** years.

3. (a) PRINT FULL NAME **Mrs Elizabeth Thomas**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **Wm Thomas** 6. (c) Age of husband or wife if alive **1** years

7. Birth date of deceased **Oct 15 1855**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | 84 | 9 | 26 | hr. min. |

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

10. Usual occupation **Housewife**

11. Industry or business **at home**

MOTHER FATHER { 12. Name **Frederick Roth**
13. Birthplace _____ (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **Mrs**
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Joseph Thomas**
(b) Address **St. Louis**

17. (a) _____ (b) Date thereof **8/15/1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peter's Cemetery, St. Louis, MO**

18. (a) Signature of funeral director **Katey H. Phillips**
(b) Address **St. Louis**

19. (a) **8/15/40** (b) _____
(Date received by local registrar) (Registrar's initials)

- MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **11** year **1940** hour **9:45** minute **45** P.M.

21. I hereby certify that I attended the deceased from **Apr 10-40** to **Aug 11 1940** that I last saw him alive on **April 10-1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma (Base Bladder)**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **46**

Major findings: Of operations _____
Of autopsy _____

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? **286**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. E. Simpson** (M. D. or other) Address **St. Louis, MO** Date signed **8/15/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 11,

District File Number.....

Date Filed.....

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.....

Lester H. Phillips
..... Licensed Embalmer No. 1898

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.