

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36837**
Registrar's No. **9110**

Registration District No. **791**

Primary Registration District No. **1003**

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 town)
(c) Name of hospital or institution:
St. Anthony Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day** (Specify whether
In this community **4 yrs**
years, months or days)

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State. **Mo** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4536 Laclede Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **Life** years.

8. (a) PRINT FULL NAME **Virginia Louise Thompson**

9. (b) If veteran, name war **None** 9. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 11th. 1924**
(Month) (Day) (Year)

8. AGE: Years **16** Months **3** Days **23** If less than one day _____ hr. _____ min.

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

10. Usual occupation **School Girl**

11. Industry or business **None**

12. Name **Robert I Thompson**

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

14. Maiden name **Emily Goree**

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

16. (a) Informant **Robert I Thompson**

(b) Address **4536 Laclede Ave.**

17. (a) **Burial** (b) Date thereof **11/6/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemt**

18. (a) Signature **Harrigan & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

19. (a) **NOV 5 1940** (b) **J.F. Budick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** 4th.
year **1940** hour **11:00 PM** minute _____ M.

21. I hereby certify that I attended the deceased from **Oct 15, 1940**
to **Nov 4, 1940**
that I last saw h. **alive on Nov 4, 1940.**
and that death occurred on [the date and hour stated above.

Immediate cause of death
Suppurated varicoides of right subal veins
Due to **Right ovarian cyst**
Due to **non-malignant**
Other conditions **121**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations: **Rt. cystic ovary**
Resident appendicitis
Of autopsy: **Suppurated varicoides Rt subal ligament**
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 **Blanche Kelly M.D.** (M.D. or other)
Address **5545 S. Grand** Date signed **11/5/40**

Dr. P. Emmet Kelly
5545 A Grand
Rd 4401 Springfield
Rd 4044 Office
ME 3285 - Rev. 1

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 Horner W. Fritz
Licensed Embalmer No. 3882

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.