

S. No. 2
-1-4-41
5-17-39
P I X26390

DEPARTMENT OF COMMERCE
REGISTERED UNDER THE CONSUMER
FILED APR 13 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9304
2680

State File No.

Registrar's No.

Registration District No. 791

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 Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community _____
years, months or days

3. (a) PRINT FULL NAME Thompson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced NB 0
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 23 42
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day 1 7 hr 5 min

9. Birthplace St. Louis 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Forrest Thompson
13. Birthplace Unknown 0 Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Vernita Johnson
15. Birthplace St. Louis 0 Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant father Mrs. Shepard
(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof MAR 26 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ira Hamilton
(b) Address City Herald Dept

19. (a) MAR 25 1942 (b) J. F. Reed
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4243 W. Maffitt Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 24
year 42 hour 12:00 minute 40 P.M.
21. I hereby certify that I attended the deceased from 2-23
42 to 2-24 19 42
that I last saw her alive on 2-24- 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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 Barrett (M. D. or other) _____
Address 2601 N. Whittier St. Date signed _____

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

0892

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.....

Licensed Embalmer No.....

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, fact should be so stated above.