S. No. 2
M—2-43
5-17-39
1 X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5816

State File No.

FILED MAR 6 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1972

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 2-15-44 to 2-27-44 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Marion

(c) City or town Odinn Ill. (If outside city or town limits, write "RURAL") NR

(d) Street No. Odin Ill, R R 1 (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Susie Jane Thomas,

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Charles Edward Thomas

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased March (Month) 4 (Day) 1886 (Year)

8. AGE: Years 57 Months 11 Days 23 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Henry Harrison

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

MOTHER 14. Maiden name Emaline Bailey

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

16. (a) Informant Henrietta Buchanan

(b) Address Isolation Hospital

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Duncan Okla.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) FEB 28 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEbruary day 27 year 44 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2 - 15, 44, to 2 - 15, 1944 that I last saw her alive on 2 - 27-44, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis with uremia

Due to

Due to

Other conditions Meningococcic meningitis
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

Duration

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 C. W. Maxwell (M. D. or other)

Address 5600 Arsenal Date signed 2-27

(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 John Ogonoski

Licensed Embalmer No. 2398

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.