

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:
St. Mary's Infirmary
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Lillie Thomas

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Paul Thomas 6. (c) Age of husband or wife if alive About 59 years

7. Birth date of deceased February 22 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	8	9	_____ hr. _____ min.

9. Birthplace Calloway County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mack Curtis

13. Birthplace Calloway County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Margaret Garry

(b) Address San Francisco, California

17. (a) Burial (b) Date thereof 11-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City, Mo.

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

(b) Address NOV 4700 Washington Blvd.

19. (a) NOV 1 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery 70
(c) City or town Montgomery City 1
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) NR
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31
year 1944 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Oct 14
1944 to Oct 31 19____

that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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) _____ (e) Means of injury _____

While at work? _____
23. Signature W. J. ... (M. D. or other) _____
Address 2316 ... Date signed _____

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

020
17
9

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 Agnoski

Licensed Embalmer No. *3398*

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.