

S. No. 2
4-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 5 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36420

State File No. _____
Registrar's No. 9967

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(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: Mo Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

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

4. Sex Male 0
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 5th 1879
(Month) (Day) (Year)

8. AGE 65 Years 9 Months 17 Days
If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Carter Carbomotor Co

MOTHER FATHER
12. Name Unknown
13. Birthplace " A
(City, town, or county) (State or foreign country)
14. Maiden name "
15. Birthplace " A
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Effie Newton
(b) Address 3614 A St. Louis ave.

17. (a) Burial (b) Date thereof 11/25/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan Bro's
(b) Address 2849 N. Euclid ave

19. (a) NOV 24 1944 (Date received local registrar)
J. J. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town St. Louis Mo. 17
3614 A St. Louis ave. (If outside city or town limits, write "RURAL") 11
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 11

MEDICAL CERTIFICATION
NOV 22
20. DATE OF DEATH: Month NOV day 22
year 1944 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov 20 44
19 44 to Nov 22 44
that I last saw him alive on Nov 22 44
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral apoplexy
Hypertension
Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)
Chronic myocarditis
Auricular fibrillation
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?
While at work? (Specify type of place) (b) Means of injury
23. Signature G. H. Kulkarni (M. D. or other)
Address 3121 Grand Date signed 11/22/44

Dr, Kilker Frank. 1244
3121 N. Grand ave.

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

Robert L. Pinkman

Licensed Embalmer No. 3553

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.