

FILED FEB 13 1945

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **370**

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch
(If not in hospital or institution, write street number or location) @
(d) Length of stay: In hospital or institution 16 1/2 days
(Specify whether
In this community 24 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 2605 Gamble
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME

Sam Thompson

3. (b) If veteran, name war - 3. (c) Social Security No. yes

4. Sex M Color or race N 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna Thompson 6. (c) Age of husband or wife if alive - years
7. Birth date of deceased (Month) 5 (Day) 80 (Year)

8. AGE: Years 64 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation elevator operator

11. Industry or business

12. Name John Thompson
13. Birthplace Centerville Tenn (City, town, or county) (State or foreign country)
14. Maiden name Clara Ruddy
15. Birthplace Centerville Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Koch Hsp, Koch Mo

17. (a) burial (b) Date thereof Feb 7/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director J. A. Green
(b) Address 2915 Eschelman ave.

19. (a) 2/6/45 (b) E. J. McLaussen (M.D.)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month 2 day 2
year 45 hour 2 minute 23 P. M.

21. I hereby certify that I attended the deceased from 8-14
19. 44, to 2-2-1945

that I last saw h. (h) alive on 2-2-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 10 months

Due to

Due to

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Major findings: Adhesive Pericarditis
Of operations Compensated aortic

Of autopsy 13H

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 1

Signature Bernard Friedman (M. D. or other) M.D.
Address Robert Koch Hsp, Koch Mo Date signed 2/3/45

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

600

APR 17 1945

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 *J. A. Green*
Licensed Embalmer No. *2963*
P. O. Address *2915 Franklin*

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.