

Registration District No. ....

318

Primary Registration District No. ....

1003

Registrar's No. 4911

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 5 years  
years, months or days

3. (a) PRINT FULL NAME JULIA THOMAS

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 divorced

6. (b) Name of husband or wife Frank Thomas

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

7. Birth date of deceased Oct 21 1957  
(Month) (Day) (Year)

8. AGE: Years 87 Months 10 Days 25  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Leola Jones

(b) Address 3960 Delmar Blvd.

17. (a) Burial (b) Date thereof June 4/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director E. B. Rooney

(b) Address 1221 N. Grand Blvd.

19. (a) JUN 9 (b) 1945  
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3960 Delmar Blvd.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31<sup>st</sup>  
year 1945 hour 12 minute 25 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Right Hip  
Afternoon suffered after  
Reported fell to the floor at her  
home 3960 Delmar Blvd. on  
12-19-45 at about 5:30 P.M.

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) Accident

(b) Date of occurrence May 12 1945

(c) Where did injury occur? At home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury As above

23. Signature Thomas F. Callahan (M. D. or other)  
Address Carroll Date signed 6-4-45

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

**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 W. Claude Gordon  
Licensed Embalmer No. 3489  
P. O. Address 4575 - Aldene

**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.**

Registration District No. 318

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

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Frank 6. (c) Age of husband or wife if alive 21 years  
7. Birth date of deceased Oct 21 (Month) (Day) (Year)

8. AGE: 87 Years 7 Months 7 Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) AUG 20 1945 (b) J. F. Bredek (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar Year 1945 hour 10 minute 00 M.  
21. I hereby certify that I attended the deceased from 10 to 19 19.....  
that I saw him alive on 10 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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



