

S. No. 2
M-5-43
v. 5-17-39
p. I X30671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18285

FILED JUN 4 1945

State File No. _____

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1042

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

1. PLACE OF DEATH:

(a) County South Kinloch Park
(b) City or town St. Louis
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME Thomas, Hazel

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

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

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation Housework

11. Industry or business Not known

12. Name Not known

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

14. Maiden name Not known

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

16. (a) Informant Hazel Thomas Perry
(b) Address 1 Kinloch Park _____

17. (a) Burial (b) Date thereof 5-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director A. H. Beal
(b) Address 2726 Lucas Ave

19. (a) MAY 2 1945 (b) E. B. M. P. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town South Kinloch
(If outside city or town limits, write "RURAL")

(d) Street No. 12 Lurch
(If rural, give location)

(e) Citizen of foreign country? _____ (If yes, name country)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 1945 hour 3 minute ? M.

21. I hereby certify that I attended the deceased from 3-25-45, 19____, to 4-26-45, 19____; that I last saw her alive on 4-26-45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung
Due to _____
470

Other conditions Pleural effusion
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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? _____
(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 John A. Wilson (M. D. or other) M.D.
Address 600 So. Brentwood Date signed 4-30-45

Duration ?
?
?
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4321*

P. O. Address. *1154 Bayard St.*

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.