

FILED SEP 7 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 7557

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Hrs. 25 Min.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1126a N. Jefferson  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Valerie Thompson

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 1

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 8 (Month)

9 (Day)

45 (Year)

8. AGE:

Years

Months

Days

If less than one day

6 hr. 25 min.

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

Missouri  
(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Louis Thompson

13. Birthplace Little Rock  
(City, town, or county)

Arkansas  
(State or foreign country)

14. Maiden name Vera Vinson

15. Birthplace St. Louis  
(City, town, or county)

Missouri  
(State or foreign country)

16. (a) Informant Mary T. Duwall  
(b) Address 2601 N. Whittier Street

17. (a) Buried (b) Date thereof AUG 30 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address City Health Dept

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10  
year 1945 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from 10:35 P.M.  
8 - 9, 1945 to 5:00 A.M. 8-10, 45  
that I last saw her alive on 8 - 10, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Prematurity

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)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. J. Sankler (M. D. XXXX)

Address 2601 N. Whittier Date signed 8-30-45

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

MOTHER FATHER

00  
17  
9

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**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.....

Licensed Embalmer No.....

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.**