S. No. 2
M—2-43
5-17-39
P I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25381

State File No.

FILED AUG 9 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6615

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

24231

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96

(c) City or town Village of St Ann
(If outside city or town limits, write "RURAL")

(d) Street No. 3576 St Christopher N.R.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Thomas Imlay

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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 April 29th 1940
(Month) (Day) (Year)

8. AGE: Years 6 Months 2 Days 29 ~~11~~ If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Joseph N Nellie
13. Birthplace Janesville Wisconsin
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Marcella Robinson
15. Birthplace Peoria Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Imlay
(b) Address 3576 St Christopher Lane

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30th
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield Ill.

18. (a) Signature of funeral director Collier's Funeral home
(b) Address 10123 St Charles Road

19. (a) JUL 29 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 28
year 1946 hour 8 minute 33 P.M.

21. I hereby certify that I attended the deceased from July 28
July, 19..., to ..., 19...;
that I last saw him alive on July 28, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus. Duration Stat

Due to Followed op for Intest obstruction

Due to Cyst of Mesentery not malignant ?

Other conditions Subacute Appendicitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations Tumor (Cyst) of Mesentery obstruction of intestine Appendicitis
Of autopsy None

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 John D Haynard (M. D. or other)

Address Metropolitan Bldg Date signed 7/29/46

(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Chas. R

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.