

No. 2
5-43
17-39
X36671

FILED DEC 24 1946
318

Registration District No. _____
Primary Registration District No. **1003**

Registrar's No. **10672**

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: **D. Paul 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 _____
years, months or days

3. (a) PRINT FULL NAME **Kate Thomson**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** / 5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Widowed**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Nov. 23rd. 1878**
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| 68 | 0 | 18 | hr. _____ min. |

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Dolan**

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

14. Maiden name **Margaret Garen**

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

16. (a) Informant **John Nolan**

(b) Address **5058 Northland Ave.**

17. (a) **Burial** (b) Date thereof **12/14/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Sullivan Funeral Dir**
2849 North Euclid Ave.

19. (a) **DEC 13 1946** (Date received at registrar)
J. F. Medeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

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

(d) Street No. **5058 Northland Ave.**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **11th.**
year **1946** hour **5.10** minute _____ P.M.

21. I hereby certify that I attended the deceased from **10-5-44** to **12-11-46**
that I last saw her alive on **12-11-46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**

Due to **Arteriosclerosis**

Due to _____

Other conditions _____
(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? _____
(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)

(a) Means of injury _____

Signature **Alvin J. [Signature]** (M. D. or other)

Address **475 2 Maryland**

Date signed **12-12-46**

Duration **5 days.**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Oliver Abel Jr.
1495 Maryland
No 3844

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 *Robert L. Brubaker*

Licensed Embalmer No. *5335*

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.