

No. 2  
-12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
FILED APR 14 1947

# THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 12010  
Registrar's No. 828

Registration District No. \_\_\_\_\_ Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis Koch  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Robert Koch Hosp. D  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 Days (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME John Henry Thomas  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 2 5. Color or race negro 6. (a) Single, widowed, married, divorced, Separated  
 6. (b) Name of husband or wife Edna Thomas 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 12 28 1905  
 (Month) (Day) (Year)

8. AGE: Years 41 Months 3 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business Vinson Hide + Tallow Co

12. Name Misc Thomas

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

14. Maiden name Carrie

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

16. (a) - Informant Koch Hosp. Records

(b) Address \_\_\_\_\_

17. (a) BURIAL (b) Date thereof 4-12-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St

19. (a) 4-11-47 (b) Robert Koch Hosp  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17  
 (c) City or town St. Louis 9  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1807 Cann St. 1  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8  
 year 1947 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from 2-11  
1947 to 4-8 1947  
 that I last saw h. (a) alive on 4-7-47 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 3 mos

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_ 13th

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) (c) Means of injury 0

23. Signature M. Q. Namer (M. D. or other) MD

Address Robert Koch Hosp. Date signed 4-9-47

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 L Boep  
....., Registered Apprentice No. MM  
working under my personal supervision.

Signed

Lornio Boyer

Licensed Embalmer No.

2946

P. O. Address

St Louis mo

**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.**