

No. 2  
-5-43  
-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 23 1947**  
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
1000

State File No. **15727**  
Registrar's No. **3679**

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

**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:  
4133a West Kossuth Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days)

**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. 4133a West Kossuth Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

**3. (a) PRINT FULL NAME** Elbridge S. Tompkins  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex male | 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Lillian D. Tompkins  
6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased 12 3 1868  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
78 4 2 hr. min.

**9. Birthplace:** Illinois  
(City, town, or county) (State or foreign country)

**10. Usual occupation:** Director of Industrial Bur

**11. Industry or business:** Chamber of Commerce

**12. Name:** Charles Tompkins

**13. Birthplace:** Rhode Island  
(City, town, or county) (State or foreign country)

**14. Maiden name:** Missie Trizzel  
(City, town, or county) (State or foreign country)

**15. Birthplace:** unknown  
(City, town, or county) (State or foreign country)

**16. (a) Informant:** Mrs. Lillian D. Tompkins

**(b) Address:** 4133a West Kossuth Ave.

**17. (a) burial** (b) Date thereof 4/8/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

**18. (a) Signature of funeral director:** Drehmann-Harrah

**(b) Address:** 1905 Union Blvd.

**19. (a) APR 7 1947** (b) J. J. Bruesch  
(Date received local registrar's certificate) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month 4 day 5  
year 1947 hour 6 minute P.M.

**21. I hereby certify that I attended the deceased from** Mar 21  
1947 to Apr 5 1947  
that I last saw him alive on Mar 21 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vasc. occlusion Duration 2 weeks

Due to Cerebral 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)  
(e) Means of injury.....

**23. Signature** C. Kleinschmidt (M. D. or other)  
Address 508 N. Grand St. Date signed 4-7-47

---

---

**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..... *Albert R. Thompson Jr*

Licensed Embalmer No..... *4237*

P. O. Address..... *St. Louis*

**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.**