

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17752
4385
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

12

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

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY None | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY none | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis | | c. LENGTH OF STAY (In this place) 0 | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis | | 17 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital | | | d. STREET ADDRESS (If rural, give location) 4920 Page Blvd. | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Thompson c. (Last) Thompson | | | 4. DATE OF DEATH (Month) (Day) (Year) May 13 1949 | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | 8. DATE OF BIRTH Unk 1885 | 9. AGE (In years last birthday) abt 63 | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Tuka, Mississippi | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Unavailable | | 13b. MOTHER'S MAIDEN NAME Tennie -- Unavailable | 14. NAME OF HUSBAND OR WIFE Unavailable | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fannie Torian, 779 N. Euclid | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH 9 days |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | | | |
| | ANTECEDENT CAUSES Undetermined | | | | |
| | DUE TO (b) Undetermined | | | | |
| | DUE TO (c) None | | | | |
| | II. OTHER SIGNIFICANT CONDITIONS None | | | | |
| | Conditions contributing to the death but not related to the disease or condition causing death. | | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 85 | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 391X | | | |
| 22. I hereby certify that I attended the deceased from 5-4 , 19 49 , to 5-13 , 19 49 , that I last saw the deceased alive on 5-13 , 19 49 , and that death occurred at 1:35p m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) Walter L Daniels M. D. | | | 23b. ADDRESS 2601 N Whittier St | | 23c. DATE SIGNED 5-16-49 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 5-17-49 | 24c. NAME OF CEMETERY OR CREMATORY St. Helens Cem | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. | | |
| DATE REC'D BY LOCAL REG. MAY 17 1949 | REGISTRAR'S SIGNATURE J. B. Lester | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas. J. Gates, 4107 Finney Ave | | |

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.....

working under my personal supervision.

Student
Student Embalmer

Signed

Student Embalmer No.

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.