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FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35648

State File No. 9118

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)		d. STREET ADDRESS (If rural, give location)			
OR TOWN <i>ST. LOUIS</i>				OR TOWN <i>ST. LOUIS</i>		d. STREET ADDRESS <i>2912 Thomas</i>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Homer G Phillips Hospital</i>									
3. NAME OF DECEASED (Type or Print) a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<i>Minnie</i>				<i>Thomas</i>		<i>Oct. 22 1949</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i>		8. DATE OF BIRTH <i>Unknown abt</i>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 28 HRS. Hours Min.			
<i>54</i>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ret</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Miss</i>		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME <i>Willis Brady</i>		13b. MOTHER'S MAIDEN NAME <i>American</i>		14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Sullivan Smith 2912 Thomas</i>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<i>Cerebral Thrombosis</i>				<i>Undet.</i>			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES							
		DUE TO (b) <i>Arteriosclerotic Heart Disease with</i>							
		DUE TO (c) <i>Decompensation</i>							
		II. OTHER SIGNIFICANT CONDITIONS							
		<i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				<i>None</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
						<i>930</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>332X</i>					
22. I hereby certify that I attended the deceased from <i>10-12</i> , 19 <i>49</i> , to <i>10-22</i> , 19 <i>49</i> , that I last saw the deceased alive on <i>10-22</i> , 19 <i>49</i> , and that death occurred at <i>2:30a</i> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>James Hedrick M. D.</i>				23b. ADDRESS <i>2601 N Whittier St</i>		23c. DATE SIGNED <i>10-22-49</i>			
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE <i>Oct 24 1949</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Canton</i>		24d. LOCATION (City, town, or county) (State) <i>Min.</i>			
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <i>Oct 24 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Lasater</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>F. C. Green 4214 Delmar</i>					

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed J. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delaware

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.