

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3599

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis		c. LENGTH OF STAY (In this place) 30 Yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips-Hospital		d. STREET ADDRESS (If rural, give location) 3141, Laclede Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) c. (Last) Thomas			4. DATE OF DEATH (Month) (Day) (Year) 4 - 18 - 19 50		
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5. SEX Male 2	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 2	8. DATE OF BIRTH 4 - 8th - 1900	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Soulin Steel Co		11. BIRTHPLACE (State or foreign country) Rich. Cohoma Co., Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A	
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13a. FATHER'S NAME James Thomas		13b. MOTHER'S MAIDEN NAME Katie, Bailey		14. NAME OF HUSBAND OR WIFE			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Ym. no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 194-09-5384		17. INFORMANT'S SIGNATURE OR NAME Delta Wilson		ADDRESS 3752 Couzens Avenue	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Pituitary Lobe Proliferation				INTERVAL BETWEEN ONSET AND DEATH	
		II. OTHER SIGNIFICANT CONDITIONS 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 type="checkbox"/> NO <input type="checkbox"/>	
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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) St Louis cos	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 490X	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 4/17, 1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter Perry Deputy Coroner		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4/19/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-22-1950		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		24d. LOCATION (City, town, or county) (State) ST. Louis, Mo	
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DATE REC'D BY LOCAL REG. APR 20 1950		REGISTRAR'S SIGNATURE J. B. Parater		25. FUNERAL DIRECTOR'S SIGNATURE Edmund Houston		ADDRESS 2829 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

[Handwritten mark]

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 _____

Licensed Embalmer No. 4441

P. O. Address 2829 Washington Bl

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.