

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25106  
6423  
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) ST. LOUIS		c. LENGTH OF STAY (in this place) 2 Months	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 220 S. JEFFERSON, AV	
3. NAME OF DECEASED (Type or Print) Thomas		4. DATE OF DEATH (Month) (Day) (Year) 7-25 50	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH OCT. 13. 1919	
9. AGE (In years last birthday) 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME JAMES H NELSON		13b. MOTHER'S MAIDEN NAME DELICINE LOMAX	
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) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME DELICINE NELSON 220 S. JEFFERSON	
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) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH Undet.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		DUE TO (b) Undetermined DUE TO (c)	
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)	
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? PO2X		22. I hereby certify that I attended the deceased from 5-19, 19 50, to 7-25, 19 50, that I last saw the deceased alive on 7-25, 19 50, and that death occurred at 8:55a. m., from the causes and on the date stated above.	
23a. SIGNATURE Oliver Thompson		23b. ADDRESS 2605 N. Whittier	
23c. DATE SIGNED 7/26/50		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE July 29, 1950		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD	
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO		25. FUNERAL DIRECTOR'S SIGNATURE Luke Jones	
DATE REC'D BY LOCAL REG. JUL 27 1950		REGISTRAR'S SIGNATURE J. B. Sasser	
25. FUNERAL DIRECTOR'S SIGNATURE Luke Jones		ADDRESS 1349 N. Harrison	

WRITE PLAINLY—USING 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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed Arthur L. Heilliard

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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.