No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28732

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7207

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

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2189
d. STREET ADDRESS (If rural, give location): 18 3403 Hickory 0

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle)
c. (Last): Thomas

4. DATE OF DEATH (Month) (Day) (Year): August 22 1950

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED, ~~NEVER MARRIED~~, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: ~~Aug 2~~ Nov. 24 1890
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Common Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Janitor
11. BIRTHPLACE (State or foreign country): 9
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Tena Scott
14. NAME OF HUSBAND OR WIFE: Ida Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME 3403 **ADDRESS**: Ida Thomas Hickory

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Undetermined

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 332X

22. *I hereby certify that I attended the deceased from* 7-29, 19 50 *to* 8-22, 19 50 *that I last saw the deceased alive on* 8-22, 19 50 *and that death occurred at* 9:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. J. Thompson M.D.
23b. ADDRESS: 2701 N Whittier St
23c. DATE SIGNED: 8-24-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 26/50
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): St Louis Co. Mo

DATE REC'D BY LOCAL REG.: AUG 24 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: G. W. Bruce 4469 Washington

(Licensed Embalmer's Statement on Reverse Side)

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 H. P. Stark

Licensed Embalmer No. 4599

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.