

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31735

State File No.

FILED SEP 22 1950

7793

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|---|--|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 100a | | 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 town or township) St. Louis | | | | c. LENGTH OF STAY (in this place) _____ | | | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | | | d. STREET ADDRESS (If rural, give location) 3661 Finney Ave. | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) James | | b. (Middle) _____ | | c. (Last) Jethro | | 4. DATE OF DEATH (Month) (Day) (Year) 9 12 '50 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Divorced | | 8. DATE OF BIRTH October 22, 1908 | | 9. AGE (In years last birthday) 41 # UNDER 1 YEAR 10 Months 20 Days # UNDER 2 HRS. 0 Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) Laurel, Mississippi | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME Sanford Jethro | | | 13b. MOTHER'S MAIDEN NAME Hettie Graham | | | 14. NAME OF HUSBAND OR WIFE _____ | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 498-20-9104 | | 17. INFORMANT'S SIGNATURE OR NAME Ida Bell Thompson | | ADDRESS 2600 Garrison | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i> | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of right lung with metastases | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown | | | |
| ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> | | | | DUE TO (b) Irreversible surgical shock Lower nephron nephrosis acidosis | | | | | | | |
| DUE TO (c) (Co 2 Saturation | | | | II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> | | | | None | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION None | | | | 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) _____ | | 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? 162X | | | | | | | |
| 22. I hereby certify that I attended the deceased from 8-13-50 , 19____, to 9-12-50 , 19____, that I last saw the deceased alive on 9-12-50 , 19____, and that death occurred at 10:30 a.m. , from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Ida Bell Thompson M. D. O. | | | | 23b. ADDRESS 2601 N. Whittier | | | | 23c. DATE SIGNED 9-12-50 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 9-18-50 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | | | | |
| DATE REC'D BY LOCAL REG. SEP 14 1950 | | REGISTRAR'S SIGNATURE [Signature] | | | | 25. FUNERAL DIRECTOR'S SIGNATURE E. B. France | | ADDRESS 1221 N. Grand | | | |

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

mit

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 Embalmer No.....

Signed.....

James C. [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. *4755*

P. O. Address *1221 N. York*

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.