

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31948**
Registrar's No. **8020**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 St. Louis, TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis, TOWN 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1419 N. Sarah St.,	

3. NAME OF DECEASED (Type or Print) a. (First) Betty	b. (Middle) Jean	c. (Last) Thompson	4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1950
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 21, 1933	9. AGE (In years last birthday) 17	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.,	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Sylvester Furguson	13b. MOTHER'S MAIDEN NAME Dorothy Thompson	14. NAME OF HUSBAND OR WIFE
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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. None	17. INFORMANT'S SIGNATURE OR NAME Essie Thompson	ADDRESS 1419 N. Sarah St.,
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) Hemorrhage from DUE TO (c) Peptic Ulcer		
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 checked="" 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)
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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? 5401
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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 _____, 19____, and that death occurred at **6:20 P. m.,** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gabriel L. Taylor, M.D. Coroner	23b. ADDRESS 1500 Clark	23c. DATE SIGNED 9-22-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/23/50	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL BOARD SEP 22 1950	REGISTRAR'S SIGNATURE J. B. Laester	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry,	ADDRESS 4202 Finney Ave.
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WRITE PLAINLY—USING UNFAADING 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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

Melvin E. Green

Licensed Embalmer No. *4428*

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.