

FILED MAR 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10669
Registrar's No. 1771

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 Ill. b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MADISON

d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN

d. STREET ADDRESS (If rural, give location) 1420 4th ST.

3. NAME OF DECEASED
a. (First) WANDA b. (Middle) LOU c. (Last) THOMPSON

4. DATE OF DEATH (Month) (Day) (Year) 2-22-52

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE

8. DATE OF BIRTH 6-29-40

9. AGE (In years last birthday) 11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) McCROCKY Ark

12. CITIZEN OF WHAT COUNTRY? AMERICA

13a. FATHER'S NAME William A. Thompson

13b. MOTHER'S MAIDEN NAME EULA MAE GLASCO

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)

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME, ADDRESS J. Egan 500 So Kings Highway

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) Post operative intractable shock
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Lung abscess.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH _____

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) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15, 1952, to 2-22, 1952, that I last saw the deceased alive on 2-22, 1952, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. L. J. Gerson M.D.

23b. ADDRESS 500 So Kings Highway

23c. DATE SIGNED 2-22-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 2-24-52

24c. NAME OF CEMETERY OR CREMATORY Macadonia Magnus

24d. LOCATION (City, town, or county) (State) ARK.

DATE REC'D BY LOCAL REG. FEB 25 1952

REGISTRAR'S SIGNATURE Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS Thompson Wilson McCroky Ark.

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

STATEMENT BY LICENSED EMBALMER

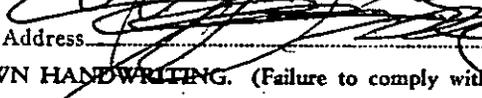
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed .....
Student Embalmer No.

Licensed Embalmer No. .....

P. O. Address. .....

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.