

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

MAY 9 - 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 334

1000

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

1. PLACE OF DEATH a. COUNTY SAINT LOUIS		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 TOWN KOCH (rural)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROBERT KOCH HOSPITAL		d. STREET ADDRESS (If rural, give location) 3116 LUCAS	
3. NAME OF DECEASED (Type or Print) a. (First) ADLEANE		b. (Middle) *	
		c. (Last) THOMAS	
		4. DATE OF DEATH (Month) (Day) (Year) 2/4/52	
5. SEX FEMALE 3	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 7/2/93(?)
9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) MACON, MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME SMITH BURTON		13b. MOTHER'S MAIDEN NAME ANGELINE?????	
14. NAME OF HUSBAND OR WIFE MAGIE THOMAS (deceased)			
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 HOSPITAL RECORDS, ROBT. KOCH HOSPITAL		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY HEMORRAGE		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		4 yrs(?)	
II. OTHER SIGNIFICANT CONDITIONS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/26/1919, to 2/4/1952, that I last saw the deceased alive on 2/4/1949 and that death occurred at 9:05 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Name or title) <i>Harold G. Russell, M.D.</i>		23b. ADDRESS ROBERT KOCH HOSPITAL	
		23c. DATE SIGNED 2/4/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 2/19/52	24c. NAME OF CEMETERY OR CREMATORY SHIPPED TO	24d. LOCATION (City, town, or county) (State) MACON, T TENNESSEE
DATE REC'D BY LOCAL REG. 2-8-52	REGISTRAR'S SIGNATURE <i>Herbert R. Donke</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>E. B. Kooze</i> ADDRESS 1221 N. GRAND	

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 Charles Spence

Licensed Embalmer No. 4752

P. O. Address 1221 N. 4th

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.