

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22744

FILED JUL 15 1952

State File No. ....

BIRTH NO. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

4414

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

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) St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2199
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			d. STREET ADDRESS (If rural, give location) 19 4004 Westminster 0		
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) Perry	c. (Last) Thomas Jr.	4. DATE OF DEATH (Month) (Day) (Year) May 12, 1952	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan. 6, 1951	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR 4 Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Paragould, Ark. /		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME James P. Thomas Sr.		13b. MOTHER'S MAIDEN NAME Maxine Blackburn		14. NAME OF HUSBAND OR WIFE None	
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 ADDRESS Maxine Thomas, 4004 Westminster		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <i>Interstitial Pneumonitis</i>  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 <input type="checkbox"/> NO <input 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 (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 525X				
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 3:55 Am., from the causes and on the date stated above.					
23a. SIGNATURE <i>Patrick Clayton Cromer</i> (Degree or title)			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 5-12-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-12-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Finch, Ark.		
DATE REG'D BY LOCAL REG. MAY 12 1952	REGISTRAR'S SIGNATURE <i>Albert H. Hoppe</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd		

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

*M. W. Ruster*

Licensed Embalmer No. 4865

P. O. Address St Louis Mo

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.