

FILED JUL 26 1954

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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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		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis, Mo</i>		c. CITY OR TOWN <i>St. Louis</i>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place)		STREET ADDRESS (If rural, give location) <i>5100 Arsenal St.</i>		<i>2139</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital					

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) M c. (Last) THOMPSON			4. DATE OF DEATH (Month) (Day) (Year) June 28, 1954		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) div	
8. DATE OF BIRTH 12/28/78		9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	
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 (City and State or Foreign Country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME William Thompson		13b. MOTHER'S MAIDEN NAME Mary Raines		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 St. Louis State Hospital	
ADDRESS					

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, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis					
		DUE TO (c)					
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 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 334x			

22. I hereby certify that I attended the deceased from **Jan. 1, 1945**, to **June 28, 1954**, that I last saw the deceased alive on **June 28, 1954**, and that death occurred at **5:55p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>L. A. O'Connell M.D.</i>		23b. ADDRESS 5100 Arsenal St.		23c. DATE SIGNED 6/29/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-31-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. JUL 13 1954		REGISTRAR'S SIGNATURE <i>J. C. Smith Mo</i>		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	
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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.....
Signature of Student Embalmer

Signed.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.