

FILED JAN 18 1955

STANDARD CERTIFICATE OF DEATH

44065
State File No. 12036
Registrar's No.

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

1. PLACE OF DEATH
a. COUNTY Missouri
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 St. Louis
c. LENGTH OF STAY (in this place) 1 mo. 18 days
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips
d. STREET ADDRESS (If rural, give location) 1815 N. Garrison

3. NAME OF DECEASED (Type or Print) a. (First) Ronald b. (Middle) Twin # 2 c. (Last) Thedford
4. DATE OF DEATH (Month) (Day) (Year) 12 4 54

5. SEX Male 2
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 0
8. DATE OF BIRTH 10-17-54
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 18 IF UNDER 11 HRS. Hours Min.

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) Missouri 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME John Thedford 1/2
13b. MOTHER'S MAIDEN NAME Bertha Jackson
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 Mary A. Jett, R.R. 2601 N. Whittier 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) Intracranial Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Premature birth, neonatal death

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 351X
20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) SUICIDE HOMICIDE
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 NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-17-1954, to 12-4-1954, that I last saw the deceased alive on 12-4-1954, and that death occurred at 12:50am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William A. Linkler M. D.
23b. ADDRESS 2601 N. Whittier
23c. DATE SIGNED 12-22-54

24a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-55
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JAN 11 1955
REGISTRAR'S SIGNATURE Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE SERVICE ADDRESS
Bowland
4104 Manchester Ave.
St. Louis 10, Mo.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
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 this body is not embalmed, fact should be so stated above.

