

10287

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

2356

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY Homer Phillips Hospital		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 OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital		STREET ADDRESS (If rural, give location) 4039 Page 21190	
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle)	c. (Last) Thomas
4. DATE OF DEATH 3 12 55	5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 11, 25, 1888	9. AGE (In years last birthday) 66	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) Oklahoma Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Unkown		13b. MOTHER'S MAIDEN NAME Josephine Smith	14. NAME OF HUSBAND OR WIFE Lee Ola Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 488-10-1581	17. INFORMANT'S SIGNATURE OR NAME Lee Ola Thomas	
17. ADDRESS			
18. CAUSE OF DEATH Enter only one cause per one for (a), (b), and (c) <i>She does not mean cause of dying, such as heart failure, asthenia, etc. means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia - Undetermined Cause	
		INTERVAL BETWEEN ONSET AND DEATH Undt.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pleural Effusion	
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? 491x	
22. I hereby certify that I attended the deceased from 1-22 , 19 55 , to 3-12 , 19 55 , that I last saw the deceased alive on 3-12 , 19 55 , and that death occurred at 2:50 P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edw. B. Williams		23b. ADDRESS M.D. 2601 N. Whittier	23c. DATE SIGNED 3-14-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 18,	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
DATE REC'D BY LOCAL REG. MAR 15 1955	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jackson Funeral Home 2649 Delmar	

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

(Licensed Embalmer's Statement on Reverse Side)

AUG 2 1955

APR 2 2 1955

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

Leroy W. Barnett
Licensed Embalmer No. 450

P. O. Address 3880 E

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.