

FILED MAR 18 1955

STANDARD CERTIFICATE OF DEATH

State File No. 10290

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1989

|   |                        |  |   |
|---|------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission before)   |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.         |                        | a. STATE Missouri b. COUNTY  |   |
| c. LENGTH OF STAY (In this place) DOA   |                        | c. CITY OR TOWN St. Louis, d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital                                       |                        | STREET ADDRESS (If rural, give location) 18 4176 Manchester Ave. 2189  |   |
| 3. NAME OF DECEASED a. (First) Jesse b. (Middle) Vernon c. (Last) Thomason                          |                        | 4. DATE OF DEATH (Month) (Day) (Year) Mar. 1, 1955   |   |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married   | 8. DATE OF BIRTH October 24, 1916   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer |                        | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) 38 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min. |
| 11a. FATHER'S NAME Henry Thomason   |                        | 11b. MOTHER'S MAIDEN NAME Myrtle Plank   | 11c. NAME OF HUSBAND OR WIFE Rose Thomason  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |                        | 11. BIRTHPLACE (City and State or Foreign Country) Salem, Missouri   |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. # 2 | 16. SOCIAL SECURITY NO. NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elba Doyle, Thomason, Creve Coeur, Mo. |  |
|--|-----------------------------|--|--|

|  |  |   |                                  |
|--|--|---|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |   | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of skull<br>Brain, self inflicted in room at home at 4176 <sup>a</sup> Manchester Street 1000 am, March 1st<br>DUE TO (b) |   |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition above   |  | 955 while suffering a deep arary, ushpal aberration |                                  |

|   |  |  |
|---|--|--|
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION Suicide   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT * (Specify) Suicide   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home          | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo                     |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Mar 1 55 10 <sup>00</sup> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR E976X  |

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 11:48A m., from the causes and on the date stated above.

|  |   |  |
|--|---|--|
| 23a. SIGNATURE Joseph [Signature]                              | 23b. ADDRESS 1300 Clark   | 23c. DATE SIGNED 3/3/55                  |
| 24. BURIAL, CREMATION, REMOVAL (Specify) Removal               | 24b. DATE 3-2-55  | 24c. NAME OF CEMETERY OR CREMATORY Local |
| 24d. LOCATION (City, town, or county) (State) Dent County, Mo. | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington. |  |
| DATE REC'D BY LOCAL REG. MAR 3 1955                            | REGISTRAR'S SIGNATURE J. Earl Smith, MD                                   |  |

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

3

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, ~~and~~ by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Edmond P. Remeluis*

Licensed Embalmer No... *428*

P. O. Address *St. Louis*

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.