

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31582**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8688**

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 or township) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 3129 Locust st.			
3. NAME OF DECEASED (Type or Print) a. (First) FRANK		b. (Middle)		c. (Last) THURMAN	
4. DATE OF DEATH (Month) (Day) (Year) OCT. 3, 1955		5. SEX male		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced		8. DATE OF BIRTH 5-20-1882		9. AGE (in years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auto worker		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Thurman		13b. MOTHER'S MAIDEN NAME Mary David	
14. NAME OF HUSBAND OR WIFE unknown		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. unknown	
17. INFORMANT'S SIGNATURE OR NAME Wm. Thurman, Los Angeles, Calif.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Staphylococcal septicemia</i> ANTECEDENT CAUSES DUE TO (b) <i>Staph. pneumonia</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		INTERVAL BETWEEN ONSET AND 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?	
22. I hereby certify that I attended the deceased from 9-30 55 to 10-3-55 , that I last saw the deceased alive on 10-3- , 19 55 , and that death occurred at 12:55 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Glenon Schaefer J. M.D.		23b. ADDRESS 1515 LAFAYETTE AVE.		23c. DATE SIGNED 10-3-55.	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 10-4-55		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Belleville, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE Gaerdner, Belleville, Ill.		ADDRESS	
DATE REC'D BY LOCAL REG. OCT 5 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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 *Will C. Branson*.....

Licensed Embalmer No. *47*.....

P. O. Address *St. Louis*.....

27- Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.