

FILED JAN 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42697**
Registrar's No. **11112**

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). STATE Missouri b. COUNTY _____	
b. CITY OR TOWN St Louis	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS 3812a Folsom	2170

3. NAME OF DECEASED (Type or Print) a. (First) Clyde b. (Middle) W c. (Last) Thompson	4. DATE OF DEATH (Month) (Day) (Year) Dec 16 1955					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar 9, 1891	9. AGE (in years last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	10b. KIND OF BUSINESS OR INDUSTRY Kroger Groc Co	11. BIRTHPLACE (City and State or Foreign Country) Iberia Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A			

13a. FATHER'S NAME Grant Thompson	13b. MOTHER'S MAIDEN NAME Emma Ponder	14. NAME OF HUSBAND OR WIFE Retta Thompson
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME Pauline Mauck	ADDRESS 3737 Westminister
---	------------------------------------	--	----------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE HEART DISEASE DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.1		INTERVAL BETWEEN ONSET AND DEATH 18 HOURS 5 YEARS
--	--	--	---

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 **SEPT 1950**, to **DEC 16, 1955**, that I last saw the deceased alive on **DEC 16, 1955**, and that death occurred at **7:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Geo. A. Daman (Degree or title) _____ George H. Hanson MD	23b. ADDRESS 5203 Chipmunk	23c. DATE SIGNED 12/17/55
---	-----------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-19-55	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Greenville, North Carolina
--	---------------------------	--	---

DATE REC'D BY LOCAL REG. DEC 19 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
---	--	---	--------------------------------

mds (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *Paul A. Wachte*

Licensed Embalmer No. *478*

P. O. Address *Howland*

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.