

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

XC-9 300 485

SI-12128

FILED DEC 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

43980

11487

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. GENEVIEVE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		c. CITY OR TOWN ST. MARYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vet. Adm. Hospital		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb 10 days		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last THOMURE			4. DATE OF DEATH Month 12 Day 13 Year 56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-10	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) CINCINNATI, OHIO	
13. FATHER'S NAME TOBIE J. THOMURE			14. MOTHER'S MAIDEN NAME LENORE M. CALDWELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT VA HOSP. RECORDS, 915 N. GRAND, ST. LOUIS, MO. Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH Undetermined
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION VA		COUNTY STATE	
21. Attended the deceased from 12-3-56 to 12-13-56 and last saw him ^{her} alive on 12-13-56			
Death occurred at 12-Noon m on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Dr. F. Westphaelinger M.D.		22b. ADDRESS 915 N. Grand VA Hosp. St. Louis, Mo.	
		22c. DATE SIGNED 12-13-56	

23a. BURIAL OR CREMATION REMOVAL (Specify) Removal		23b. DATE 12-13-56		23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION (City, town, or county) (State) St. Mary's, Missouri.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,			25. DATE RECD. BY LOCAL REG. DEC 14 1956		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.		

(Licensed Embalmer's Statement on Reverse Side)

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.....
Robert M. Mur
Licensed Embalmer No.....
374

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

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