

Health,
& Welfare
Public
Service

S. 300
v. 1-56

Securing the medical certificate in this specific manner required by 1934, no more 1937.
Disease, 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

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11193
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registor's No. 1934

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ALEXIAN BROS.</i>		Length of stay in <i>2 MONTHS</i>	d. STREET ADDRESS <i>4469 BINGHAM</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Thome</i> Last <i>Thome</i>			4. DATE OF DEATH Month <i>Feb</i> Day <i>24</i> Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-1871</i>	9. AGE (In years last birthday) <i>86</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	11. BIRTHPLACE (City and state or country) <i>LEBANON, ILL.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>MATHIS THOME</i>			14. MOTHER'S MAIDEN NAME <i>ROSEMARY ?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Arnold Thome</i>		Address <i>4354 McKee St. St. Louis Mo</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO (b) <i>Senility</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>2 MO</i>
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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from <i>1-19-56</i> to <i>2-24-1957</i> and last saw her/him alive on <i>2-23-1957</i> Death occurred at <i>8th Ave.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>B. J. McGinnis M. D.</i> (Degree or title)			22b. ADDRESS <i>16 Hampton Village Pl.</i>		22c. DATE SIGNED <i>2-25-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>2-25-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>O'Fallon</i>		23d. LOCATION (City, town, or county) (State) <i>ILLINOIS</i>
24. FUNERAL DIRECTOR <i>L. M. Wolfersberg</i>		ADDRESS <i>O'Fallon, Ill</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 26 '57</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> <i>mrb</i>

(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.....
Frank Prouff

Licensed Embalmer No. 434

P. O. Address *S. Haem*

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.