

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15369

FILED APR 22 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3083**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> TOWN St. Louis		c. CITY OR TOWN Webster Groves Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 4577	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hosp. Length of stay in 1b 30yrs		d. STREET ADDRESS (If outside, give location) 940 Newport Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Walter Last Thomas			4. DATE OF DEATH Month March Day 29 Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1898
9. AGE (In years last birthday) 58yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personel Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Lincoln Eng. Co.	11. BIRTHPLACE (City and state or country) Madison, Mo
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Perry Lee Thomas	
14. MOTHER'S MAIDEN NAME Eleanor Dixon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No None	
16. SOCIAL SECURITY NO. 494-01-3443		17. INFORMANT R. Walter Thomas 940 Newport	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Cerebral Artery Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension, essential DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332x			INTERVAL BETWEEN ONSET AND DEATH Mar 24 57 years
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		COUNTY STATE	
21. I attended the deceased from 9 AM 57 to 29 Mar 57 and last saw ^{her} him alive on 28 Mar 57 . Death occurred at 7:39 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ray David Williams M.D.		22b. ADDRESS 114 N O Taylor St. Louis 8 MO	22c. DATE SIGNED 29 Mar 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE April 1, 1957	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county). (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar		25. DATE RECD. BY LOCAL REG. MAR 29 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith MO

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Dr. Williams
Grand Med Clinic

APR 23 1957

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 *Jos. E. McCulloch*

Licensed Embalmer No. *276*
P. O. Address *6145 Pal*

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.