

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012402
STATE FILE NUMBER
3325

FILED APR 9 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 3325

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Peoples Hospital		d. STREET ADDRESS 3915 W. Belle	
3. NAME OF DECEASED (Type or print) First Middle Last H I B E R N I A T H O M P S O N		4. DATE OF DEATH Month Day Year 3 18 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY pvt. family	11. BIRTHPLACE (City and state or country) Paducah, Ky. /
13a. FATHER'S NAME Andrew Lunderman		13b. MOTHER'S MAIDEN NAME Hattie Ferguson	14. NAME OF HUSBAND OR WIFE Charles Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO.	17. INFORMANT Address Anna L. Williams 3915 W. Belle
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>Subdural & Subarachnoid Hemorrhage.</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ 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 E904.021 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <i>Suffered when deceased fell in</i>	
20c. TIME OF INJURY Hour Month, Day, Year ? 3 9 58		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION St. Louis MO COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 10 15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Joseph M. Quinn</i> (Degree or title) <i>Deputy</i>		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 3/21/58			
23a. BURIAL, CREATION, REMOVAL (Specify) Removal		23b. DATE 3-24-58	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.	
24. FUNERAL DIRECTOR Charles J. Gates		25. DATE RECD. BY LOCAL REG. MAR 21 '58	
26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

health, welfare, public service
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Doctor, coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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 *Gupton Swan*

Licensed Embalmer No. *4580*

P. O. Address *4107 Fenway*

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.