

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034759  
STATE FILE NUMBER  
8436  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

FILED SEP 22 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson 4/19
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 09 De Paul Hosp.		Length of stay in 1b 3 Days	d. STREET ADDRESS (If outside, give location) 27 316 Georgia Ave.

3. NAME OF DECEASED (Type or print) First Middle Last Harry Moffet Thompson			4. DATE OF DEATH Month Day Year 8/31/58		
---	--	--	---	--	--

5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/82	9. AGE (In years) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--	---------------------------	---	-----------------------------	-------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	11. BIRTHPLACE (City and state or country) Grays Summit, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	-------------------------------------

13a. FATHER'S NAME John Thompson	13b. MOTHER'S MAIDEN NAME Ellen Adams	14. NAME OF HUSBAND OR WIFE Emma Marie St. Cyr
-------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) None	16. SOCIAL SECURITY NO. 488-10-4892	17. INFORMANT Emma Thompson	Address 316 Georgia Ave.
---	--	--------------------------------	-----------------------------

18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arteriosclerosis</i>	
	DUE TO (c) <i>Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>442x</i>		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 <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Death occurred at <i>June 1958</i> to <i>Aug. 31, 1958</i> and last saw him alive on <i>Aug. 30, 1958</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <i>Charles Mullen M.D.</i>	22b. ADDRESS <i>111 Chestnut St.</i>	22c. DATE SIGNED <i>9/1/58</i>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/3/58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	---------------------	--	---

24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd.	25. DATE RECD. BY LOCAL REG. SEP 2 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, MD</i>
--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 Eleana Bovine

Licensed Embalmer No. 3403

P. O. Address Jennings

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.