

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003571

STATE FILE NUMBER

2 911

1.3 16 1959

Registration District No.

Primary Registration District No.

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 <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, Missouri</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>4091 Kinloch, Missouri</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>De-Paul Hospital</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>1130 Lurch</i>
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Allen Thomas</i>			4. DATE OF DEATH Month Day Year <i>Jan. 22, 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 18, 1914</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years of birthday) <i>44</i>
11. BIRTHPLACE (City and state or country) <i>Jackson, Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Sine Thomas</i>		13b. MOTHER'S MAIDEN NAME <i>Willie Ozier</i>	14. NAME OF HUSBAND OR WIFE <i>Estella G. Thomas</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT Address <i>Estella Thomas 1130 Lurch</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>Pneumonia, Uremic</i>			INTERVAL BETWEEN ONSET AND DEATH <i>29 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Lower Nephrosclerosis</i>			<i>14 days</i>
DUE TO (c) <i>Peripheral Circulatory Collapse</i>			<i>14 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Pt. upper chestotomy for Congenital Cystic Lung Disease</i>			19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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.) <i>7590</i>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <i>December 1958</i> to <i>1/22/59</i> and last saw ^{her} _{him} alive on <i>1/21/59</i> Death occurred at <i>4:30 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>James C. Vest M.D.</i>		22b. ADDRESS <i>634 N. Grand, St. Louis</i>	
22c. DATE SIGNED <i>1/26/59</i>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>	23b. DATE <i>1/28/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>	23d. LOCATION (City, town, or county) (State) <i>Berkley, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>E. B. KOONCE 1221 N. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 27 '59</i>	26. REGISTRAR'S SIGNATURE <i>Charles Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Malvin Blackburn*

Licensed Embalmer No. *2967*
P. O. Address *1221 N. Grant*

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.