

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003574

STATE FILE NUMBER

2 712

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 215
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4562 Washington
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Last Thompson			4. DATE OF DEATH Month 1- Day 9- Year 59
5. SEX Fem. S	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours 8 Min. 13
11. BIRTHPLACE (City and state or country) Saint Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Uriah Thompson		13b. MOTHER'S MAIDEN NAME Verdie Conway	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Mary A. Jett, R.R. 1, 2601 N. Whittier
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 776A			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 1-8-59 , to 1-9-59 and last saw her alive on 1-9-59 Death occurred at 5:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul White, M. D.		22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 1-14-59
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-59		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)	
24. FUNERAL DIRECTOR ADDRESS Rowland Akew 4104 Manchester		25. DATE RECD. BY LOCAL REG. JAN 22 59	26. REGISTRAR'S SIGNATURE Carl Smith

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Licensed Embalmer No.....

P. O. Address.....

**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.**