

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015838

STATE FILE NUMBER
2 4268

FILED MAY 14 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 <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. BAPTIST HOSP</u>		Length of stay in 1b <u>3 WKS</u>	d. STREET ADDRESS (If outside, give location) <u>4834 GERMANIA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIOLA M. THOMAS</u>			4. DATE OF DEATH Month Day Year <u>APR. 29, 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 5, 1917</u>
9. AGE (In years last birthday) <u>42</u>		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) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>BRIGHTON ILL 1</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>JAMES F. MURPHY</u>	13b. MOTHER'S MAIDEN NAME <u>JENNIE IDA NULSEN</u>
14. NAME OF HUSBAND OR WIFE <u>ROBERT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>488-09-8791</u>
17. INFORMANT <u>ROBERT S. THOMAS SR.</u>		Address <u>4834 GERMANIA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suppurative mesenteric artery thrombosis.</u> DUE TO (b) <u>Chronic myelogenous leucemia</u> DUE TO (c) <u>204.1.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral softening, probably neoplastic.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <u>4-11-59</u> to <u>4-29-59</u> and last saw her/him alive on <u>4-29-59</u> Death occurred at <u>4:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James O. Schaefer, M.D.</u> (Degree or title)		22b. ADDRESS <u>6944 Whippewa Ave.</u>	
22c. DATE SIGNED <u>4-30-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>5/1/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CEM.</u>	
23d. LOCATION (City, town, or county) <u>ALTON, ILLINOIS</u>		(State)	
24. FUNERAL DIRECTOR <u>J. L. ZIEGENHEIN & SONS</u>		ADDRESS <u>7027 GRAVOIS</u>	
25. DATE RECD. BY LOCAL REG. <u>APR 30 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
1-57
7
293
0

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.

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 *Donald E. Berry*

Licensed Embalmer No. *4863*
P. O. Address *H. Town Ma.*

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.