

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015840

STATE FILE NUMBER

2-3187

FILED APR 20 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY <i>St. Louis City</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>22 Benton Place</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jennie</i> Middle _____ Last <i>Thompson</i>		4. DATE OF DEATH Month <i>March</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 18, 1871</i>
9. AGE (In years last birthday) <i>88</i>		10. FUNDING YEAR IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and state or country) <i>Gray Summit, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Stiles</i>		13b. MOTHER'S MAIDEN NAME <i>Susan Hoff</i>	
14. NAME OF HUSBAND OR WIFE <i>Harry Thompson (deceased)</i>		17. INFORMANT Address <i>Harry Stahl, 4917 Kirk Skokie Ill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</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>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>ARTERIO SCLEROSIS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs +</i> <i>? yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>331X</i>		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.) <i>331X</i>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>331X</i>	
20e. CITY, TOWN, OR LOCATION <i>331X</i>		20f. COUNTY STATE	
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		20g. COUNTY STATE	
21. I attended the deceased from Death occurred at <i>7-7-53</i> to <i>3-29-59</i> and last saw her alive on <i>3-29-59</i> <i>5 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Albert Kaplan M.D.</i>		22b. ADDRESS <i>607 N. Grand</i>	
22c. DATE SIGNED <i>3-30-59</i>		22d. SIGNATURE (Degree or title) <i>Carl Smith, M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>April 1</i>		23b. DATE <i>April 1</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bush Creek</i>		23d. LOCATION (City, town, or county) (State) <i>Gray Summit, Mo</i>	
24. FUNERAL DIRECTOR <i>Mrs. John L. Shuler</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 31 '59</i>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>		26. REGISTRAR'S SIGNATURE <i>Carl 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 with or without. All diseases in Part I must be causally related.

Health, Welfare, Public Service

300
1-57

90
0

APR 30 1959

STATEMENT BY LICENSED EMBALMER

APR 30 1959

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 *Ralph Oltmann*

Licensed Embalmer No. *4808*

P. O. Address *Union Mo*

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.