

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015846

STATE FILE NUMBER 23397
REGISTRATION NO. 3397

FILED APR 24 1959

Registration District No. Primary Registration District 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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3046 Thomas	

3. NAME OF DECEASED (Type or print) Sam Thurman			4. DATE OF DEATH Month 4 Day 1 Year 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years at birthday) 67	10. FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRANK THURMAN		13b. MOTHER'S MAIDEN NAME NANNIE BUNTING		14. NAME OF HUSBAND OR WIFE DISEASED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Address DONALD THURMAN 3046 THOMAS ST.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Nephrosclerosis			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 Month, Day, Year a.m. p.m.			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 3-25-59 to 4-1-59 and last saw <input checked="" type="checkbox"/> him alive on 4-1-59 Death occurred at 1:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE J. G. Inman (Degree or title) , M.D.		22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 4-3-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-8-59	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.
24. FUNERAL DIRECTOR Luke Jones ADDRESS 1343 No. Harrison Ave		25. DATE RECD. BY LOCAL REG. APR 6 '59		26. REGISTRAR'S SIGNATURE Miss Pearl Smith, M.D.	

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 Arthur L. Hellier

Licensed Embalmer No. 4221
P. O. Address 3100 Easton

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.