

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019865

STATE FILE NUMBER

**MAY 25 1959**

Registration District No. **317**

Primary Registration District No. **541**

Registrar's No. **1353**

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Wellston 4311</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp.</b>		Length of stay in lb <b>DOA</b>	d. STREET ADDRESS (If outside, give location) <b>1115 Delaware</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JIMMIE</b> Middle <b>LOREN</b> Last <b>THOMPSON</b>			4. DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1939</b>		9. AGE (In years last birthday) <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothes Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Calif. Mfg. Co.</b>		11. BIRTHPLACE (City and state or country) <b>Secucess, Arkansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Wilford Thompson</b>		
13b. MOTHER'S MAIDEN NAME <b>Lucille Walker</b>			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) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-44-1069</b>		17. INFORMANT Address <b>Lucille DeCorpe 6333 Spencer, Wellston</b>	
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive skull fractures with intracerebral sequelae</b>					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) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
20a. ACCIDENT <input checked="" 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.) <b>Motorcycle Accident - lost control of motorcycle he was operating which ran into wall of building</b>			
20c. TIME OF INJURY <b>3:00 a.m. 5-16-1959</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>			
20e. CITY, TOWN, OR LOCATION <b>Wellston</b>		20f. COUNTY <b>St. Louis</b>		20g. STATE <b>Mo.</b>	
21. I attended the deceased from <b>5-16-1959</b> to <b>5-16-1959</b> and last saw her/him alive on <b>5-16-1959</b> Death occurred at <b>3:56 P.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Raymond L. Lane</b> Coroner			22b. ADDRESS <b>Clayton, Mo.</b>		22c. DATE SIGNED <b>5/20/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Corning, Arkansas</b>		(State)			
24. FUNERAL DIRECTOR <b>Russell Ermert</b>		ADDRESS <b>Corning, Ark.</b>		25. DATE RECD. BY LOCAL REG. <b>5-16-59</b>	
REGISTRAR'S SIGNATURE <b>J. B. Murphy</b>					

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 *Clarence Billo* .....

Licensed Embalmer No. *4375* .....

P. O. Address *Alton Ill* .....

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.