

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 2327 - 60-009969** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST LOUIS CITY HOSP. #1.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> <b>3405 N. Jefferson Av.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS <b>3504 N. Jefferson Av.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>BERT</b> Middle _____ Last <b>THOMPSON</b>	<b>4. DATE OF DEATH</b> Month <b>FEB.</b> Day <b>26,</b> Year <b>1960</b>
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<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> Sept. 11, 1884	<b>9. AGE (last birthday)</b> 75	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Bricklayer	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>11. BIRTHPLACE</b> (City and state or country) Illinois	<b>12. CITIZEN OF WHAT COUNTRY</b> U.S.A.
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<b>13a. FATHER'S NAME</b> Daniel Thompson	<b>13b. MOTHER'S MAIDEN NAME</b> Nancy Taylor	<b>14. NAME OF HUSBAND OR WIFE</b> Never Married
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No	<b>16. SOCIAL SECURITY NO.</b> Unknown	<b>17. INFORMANT</b> Susan Thompson 3504 N. Jefferson Av.
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH 1 day ?
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Jaundice - Etio??</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE
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21. I attended the deceased from 2/22/60 to 2/26/60 and last saw her/him alive on 2/26/60  
 Death occurred at 11:15 A the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>John M. Kearney M.D.</u>	<b>22b. ADDRESS</b> 1515 LAFAYETTE AVE	<b>22c. DATE SIGNED</b> 2/26/60
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> removal	<b>23b. DATE</b> Feb. 29-1960	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Memorial Pk. Cemetery	<b>23d. LOCATION</b> (City, town, or county) (State) St. Louis Co. No.,
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<b>24. FUNERAL DIRECTOR</b> ADDRESS Leidner Und. Co., 2223 St. Louis Av.	<b>25. DATE RECD. BY LOCAL REG.</b> FEB 29 1960	<b>26. REGISTRAR'S SIGNATURE</b> Carl Smith, M.D.
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3071

P. O. Address St. Louis, 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.