

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-021821

STATE FILE NUMBER

FILED VS MAY 3 1 1960

Registration District No. 317

Primary Registration District No. 1200

Registrar's No. 1200

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Cedar Hill 0500,		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp. D.O.A.		Length of stay in 1 1/2	d. STREET ADDRESS (If outside, give location) Hillsboro Rt. 2		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LeRoy Middle Last Thomas			4. DATE OF DEATH Month 4 Day 10 Year 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1890		9. AGE (In years last birthday) 69 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, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Florist	11. BIRTHPLACE (City and state or country) Shannon Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Jeff Thomas		13b. MOTHER'S MAIDEN NAME Polly-Ann Goforth		14. NAME OF HUSBAND OR WIFE Delphia Thomas	
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. 500-10-3813		17. INFORMANT Address Cynthia Tuck- Rt. 1-Fenton Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-Vascular Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 3
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Cholecystitis					3
DUE TO (c) 4221					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 Jan 2-1960 to April 4-1960 and saw him alive on Apr 29-1960 Death occurred at _____ m on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) H. Y. Moore M.D.			22b. ADDRESS 917-5018		22c. DATE SIGNED May 9-1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/13/60	23c. NAME OF CEMETERY OR CREMATORY Oak Hill		23d. LOCATION (City, town, or county) (State) Kirkwood Mo.
24. FUNERAL DIRECTOR ADDRESS Leoff Lissen			25. DATE RECD. BY LOCAL REG. 4-12-60		26. REGISTRAR'S SIGNATURE J. M. B. [Signature]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Daniel J. Mahan*

Licensed Embalmer No. *4326*

P. O. Address *1055 T. O. W.*

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.