

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025023

FILED VS JUL 15 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6560**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3523 Park Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GUY Middle EARL Last THOMAS				4. DATE OF DEATH Month JUNE Day 27 , Year 1960			
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 6/19/94	9. AGE (last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Louisiana, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME August A. Thomas			13b. MOTHER'S MAIDEN NAME Martha Alice Douglas			14. NAME OF HUSBAND OR WIFE Ina Dee Johnson 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. none		17. INFORMANT Address Ina Dee Thomas 3523 Park Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) Bulbar palsy 332x							
DUE TO (c) Infarction of brain, arteriosclerotic thrombosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bilateral bronchiectasis, ASHO i and Myocard. Infarct					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		
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 a.m. p.m. Month, Day, Year							
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
		6/21/60		6/27/60		6/27/60	
21. I attended the deceased from 6/21/60 4:45 P , to 6/27/60 and last saw her him alive on 6/27/60 . 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) Victor Owell M.D.				22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 6/28/60	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/29/60	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS E.J. Schnur 3125 Lafayette Ave.				25. DATE RECD. BY LOCAL REG. JUN 28 1960		26. REGISTRAR'S SIGNATURE Earl Smith. M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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

Thomas R. Jensen

Licensed Embalmer No. 3793

P. O. Address 3125 Lay

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.