

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025025

FILED VS JUL 1 2 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6601 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Length of stay in 1b <u>12 DAYS</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET ADM HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>227 A PRESIDENT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>D.</u> Last <u>THOMPSON</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1960</u>	
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-93</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE</u>	11. BIRTHPLACE (City and state or country) <u>PUXICO, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>JOSEPH THOMPSON</u>	13b. MOTHER'S MAIDEN NAME <u>MOLLIE BUNYARD</u>	14. NAME OF HUSBAND OR WIFE <u>VIDA THOMPSON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>194-09-1892</u>	17. INFORMANT <u>VIDA THOMPSON, 227 A PRESIDENT</u>	Address <u>ST. LOUIS, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>CARDIO RESPIRATORY FAILURE ACUTE</u>	
DUE TO (b)	<u>METASTATIC DISEASE OF LIVER</u>	<u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	
	<u>G I CARCINOMA</u>	<u>2 YEARS</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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.)
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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
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21. Attended the deceased from 6-13-60 to 6-25-60 and last saw ^{him} alive on 6-25-60
Death occurred at 2:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>LEE SHENE</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>6/25/60</u>
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23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>	23b. DATE <u>6-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>	23d. LOCATION (City, town, or county) (State) <u>DE SOTO MO</u>
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24. FUNERAL DIRECTOR <u>MAHN Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 29 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1960

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 Gerald J. Martin

Licensed Embalmer No. 497

P. O. Address De Soto,

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.