

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032958

FILED VS. SEP. 8 1960 318 1003 8554 REGISTRATION DISTRICT Primary Registration District No. REGISTRAR'S NO. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3900 Cleveland</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3900 Cleveland</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>O</u> Last <u>THOMSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1960</u>					
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>12/7/1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Rockford, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>William Thomson</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Hendrickson</u>			14. NAME OF HUSBAND OR WIFE <u>Vera</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Vera Thomson</u>			Address <u>3900 Cleveland</u>	
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>CARCINOMA OF DESCENDING COLON</u>							<u>1 year</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) <u>--</u>									
DUE TO (c) <u>--</u>							<u>153.2</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>none</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			
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.) <u>--</u>					
20c. TIME OF INJURY Hour <u>--</u> Month, Day, Year <u>--</u> 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.) <u>--</u>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Nov. 1959</u> to <u>8/29/60</u> and last saw ^{THE} him alive on <u>8/29/60</u> Death occurred at <u>8/30/60 2:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Charles O. Metzner</u> (Degree, or title)				22b. ADDRESS <u>3102-A South Grand</u>			22c. DATE SIGNED <u>8/30/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>9/1/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>College Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Lebanon, Illinois</u>			(State)	
24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons 7027 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>AUG 31 1960</u>		26. REGISTRAR'S SIGNATURE <u>Neal Smith M.D.</u>			

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
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Main

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