

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

**-60-040667**  
 STATE FILE NUMBER

**FILED VS NOV 9 1960**  
 Registration District No. 317

Primary Registration District No. 500 Registrar's No. 3172

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS</b>		Length of stay in lb <b>15 DAYS</b>		c. CITY OR TOWN <b>OVERLAND</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>VETERANS ADMINISTRATION</b> INSTITUTION <b>HOSPITAL</b>				d. STREET ADDRESS (If outside, give location) <b>2329 BRISTOW AVENUE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TEAMOUS S. THOMPSON</b>				4. DATE OF DEATH Month Day Year <b>11-1-60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-89</b>	
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (City and state or country) <b>ROBINSON CITY, TENN.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>MARSHALL THOMPSON</b>			
13b. MOTHER'S MAIDEN NAME <b>POLLY (UNKNOWN)</b>		14. NAME OF HUSBAND OR WIFE <b>-----</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-I</b>		16. SOCIAL SECURITY NO. <b>284-20-2972</b>		17. INFORMANT Address <b>MRS. AGNES REEVES, ADAMS, TENNESSEE</b>			
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) <b>RENAL FAILURE</b>						<b>13 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						<b>UNDETERMINED</b>	
DUE TO (b) <b>CHRONIC PYELONEPHRITIS</b>						<b>UNDETERMINED</b>	
DUE TO (c) <b>ARTERIOLAR NEPHROSCLEROSIS</b>						<b>UNDETERMINED</b>	
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"/> 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. <b>VA 10-17-60</b>		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	
21. attended the deceased from Death occurred at <b>3:45 am</b>		to <b>11-1-60</b>		and last saw him <b>xxxxxxx</b> on <b>11-1-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James S. Nelson M.D.</b>				22b. ADDRESS <b>VA HOSP. JEFF. BRKS. MO.</b>		22c. DATE SIGNED <b>11-1-60</b>	
23a. BURIAL (Cremation, Removal (Specify) <b>Removal</b> )		23b. DATE <b>11-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>		23d. LOCATION (City, town, or county) (State) <b>Adams, Tennessee</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc. 4700 Washington</b>				25. DATE RECD. BY LOCAL REG. <b>11-2-60</b>		26. REGISTRAR'S SIGNATURE <b>John E. Murphy M.D.</b>	

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

Signature Stanley H. Wip

Licensed Embalmer No. 419

P.O. Address St. L.

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.