

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

-61-003933

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 226

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>University City</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>County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>613 Westgate</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Abigail</u> Middle <u>Thompson</u> Last <u>Thompson</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1961</u>
5. SEX <u>female</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>9-25-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE (last birthday) <u>74</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME <u>Edward O'Hara</u>		11b. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	11. BIRTHPLACE (City and state or country) <u>Cambridge, Mass.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>Oral Thompson</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>no</u>	17. INFORMANT Address <u>U. City Mo</u> <u>Oral Thompson 613 Westgate</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u> <u>4 yrs</u> DUE TO (c) <u>Arterio Sclerosis Generalized</u> <u>4 yrs</u>			PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 <u>8:00 AM</u> Month, Day, Year <u>May 1957</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>May 1957</u> to <u>22 Jan 1961</u> and last saw her <u>alive</u> on <u>21 Jan. 1961</u> . Death occurred at <u>8:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>Lois N. Magness MD</u> (Degree or title)		22a. ADDRESS <u>University City Mo</u>	22c. DATE SIGNED <u>23 Jan '61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1--25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>	23d. LOCATION (City, town, or county) <u>Manchester, Mo.</u>
24. FUNERAL DIRECTOR <u>Schrader Funeral Home Ballwin, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-23-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

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 Richard M. Bopp

Licensed Embalmer No. 4584

P. O. Address Ballwin, Mo

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.