SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3775 STATE FILE NUMBER -61-015693

FILED APR 27 1961

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 ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1 — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2301 SO. 3rd — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MICHAEL WAYNE Middle BABY BOYY Last THOMPSON

4. DATE OF DEATH Month APRIL Day 8 Year 1961

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4/8/61

9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. 43

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (City and state or country) ST.LOUIS,MO

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME NORMAN ADOLPH THOMPSON

13b. MOTHER'S MAIDEN NAME NORMA LEE HART

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address ST.LOUIS CITY HOSP. #1.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hydrocephalus.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Multiple congenital
DUE TO (c) defects
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 752x

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 4-8-61, to 4-8-61 and last saw her/him alive on 4-8-61
Death occurred at 4:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Gerald J Quilling MD

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 4-8-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE APR 29 1961

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland Aker 4104 Manchester

25. DATE RECD. BY LOCAL REG. APR 20 1961

26. REGISTRAR'S SIGNATURE Ead Smith. M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — DOCUMENT

MEDICAL CERTIFICATION

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.