

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016053

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 966

AMENDED FILED APR 17 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>  |   | Length of stay in 1b<br><u>YRS</u>   | c. CITY OR TOWN <u>Richmond Heights</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>St. Mary's Hospital</u>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>6420 Clayton Road</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                       |
| 3. NAME OF DECEASED First Middle Last<br><u>Sister Mary Mildred Thomas</u>   |   |  | 4. DATE OF DEATH Month Day Year<br><u>Apr. 6 1961</u>   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-26-1895</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.N.</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Religious worker</u>  | 9. AGE (last birthday) <u>65</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.  |
| 11. BIRTHPLACE (City and state or country) <u>Port Washington, Wisc.</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |   |
| 13a. FATHER'S NAME <u>Peter Thomas</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Emily Neyken</u>  | 14. NAME OF HUSBAND OR WIFE <u>-</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>-</u>   | 17. INFORMANT Address <u>S. Mary Francine, SSM., 1100 Bellevue Ave.</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular disease</u>   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" 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.)   |   |
| 20c. TIME OF INJURY Hour Month, Day, Year<br>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  |
| 21. I attended the deceased from <u>April 1957</u> to <u>April 6 1961</u> and last saw her <u>alive</u> on <u>March 15, 1961</u><br>Death occurred at <u>8 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |  |   |
| 22a. SIGNATURE (Degree or title) <u>Joseph V. Lunnegren M.D.</u>   |   | 22b. ADDRESS <u>634 N. Grand</u>   | 22c. DATE SIGNED <u>Apr 9 1961</u>  |
| 23a. BURIAL, CREMATION, REBURYAL (Specify) <u>George</u>   | 23b. DATE <u>4/10/61</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>   | 23d. LOCATION (City, town, or county) (State) <u>Arnold MO</u>  |
| 24. FUNERAL DIRECTOR <u>W.H. Johnson</u>   | ADDRESS <u>6536 Clayton Rd</u>  | 25. DATE RECD. BY LOCAL REG. <u>4-9-61</u>   | 26. REGISTRAR'S SIGNATURE <u>John C. Manly 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

*Stanley H. Dixon*

Licensed Embalmer No. 4193

P. O. Address. St. Louis 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.