

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004632

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

Primary Registration District No.

Registrar's No.

61

| | | | | | | | | |
|---|---|---|---|--|---|---|---|------------------------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURY</u> 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>HAMILTON MED. CENTER</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>HAMILTON MED. CENTER</u> <u>956 HAMILTON</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MCCREERY</u> Last <u>THOMSON</u> | | | 4. DATE OF DEATH Month <u>JAN</u> Day <u>2</u> Year <u>1962</u> | | | | | |
| 5. SEX <u>FEMALE</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>12-24-1875</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 24 HR Hours | IF UNDER 24 HR Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | | |
| 13a. FATHER'S NAME <u>WM. THOMSON</u> | | | 13b. MOTHER'S MAIDEN NAME <u>ANNIE HARGARDINE</u> | | 14. NAME OF HUSBAND OR WIFE <u>NONE</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>NONE</u> | | 17. INFORMANT Address <u>ANNIE HAIGLER 801 S. MCKNIGHT</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>Coronary occlusion</u> DUE TO (b) <u>Senile Changes</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</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 | | |
| 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 a.m. p.m. 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. I attended the deceased from <u>1955</u> , to <u>date of death</u> and last saw ^{her} / _{him} alive on <u>1-2-1962</u> Death occurred at <u>5P:</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>Joseph Barrie, M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>614 Missouri Theatre Bldg.</u> | | | 22c. DATE SIGNED <u>1-3-62</u> | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>1-5-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BELLEFONTAINE CEM</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u> | | | |
| 24. FUNERAL DIRECTOR <u>C. R. LUPTON & SONS</u> ADDRESS <u>7233 DENMAR</u> | | | 25. DATE RECD. BY LOCAL REG. <u>JAN 3 1962</u> | | 26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u> | | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence L. Durra

Licensed Embalmer No. 404

P. O. Address Hoover, 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.