

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1521-62-008842  
STATE FILE NUMBER

FILED FEB 16 1967  
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1521

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59  
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8/20/71  
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4 0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Ill.</b> b. COUNTY <b>Champaign</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		c. CITY OR TOWN <b>Champaign</b> d. STREET ADDRESS (If outside, give location) <b>2002 Cynthia Dr.</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>WARREN</b> Middle <b>R.</b> Last <b>THOMPSON</b>		Month <b>FEBRUARY</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Co.</b>	11. BIRTHPLACE (City and state or country) <b>Illinois Montgomery County, U.S.A.</b>
13a. FATHER'S NAME <b>Ralph Thompson</b>		13b. MOTHER'S MAIDEN NAME <b>Edith Lester</b>	14. NAME OF HUSBAND OR WIFE <b>Vera Stogdell Thompson</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	17. INFORMANT <b>Mrs. Vera Thompson, Champaign, Ill.</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>CORONARY OCCLUSION</b>			<b>4 HOURS</b>
DUE TO (b) <b>RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS AND MITRAL INSUFFICIENCY</b>			<b>15 YEARS</b>
DUE TO (c)			
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
29. 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.)			<b>410x</b>
20c. TIME OF INJURY Hour <b>2:55 P.M.</b> s.m. p.m.		20f. CITY, TOWN, OR LOCATION <b>Champaign</b> COUNTY <b>Champaign</b> STATE <b>Ill.</b>	
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.)	
21. I attended the deceased from <b>DEC. 18, 1956</b> to <b>FEB. 2, 1962</b> and last saw her/him alive on <b>FEB. 2, 1962</b> Death occurred at <b>2:55 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. D. Hemillion, M.D.</i>		22b. ADDRESS <b>BARNES HOSPITAL</b>	
22c. DATE SIGNED <b>2/3/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-7-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Camp Butler National</b>		23d. LOCATION (City, town, or county) (State) <b>Sangamon County, Ill.</b>	
24. FUNERAL DIRECTOR <b>Harold Bisch</b> <b>Bisch Memorial</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 5 1962</b>	
ADDRESS <b>Springfield, Ill.</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Kassly III

Licensed Embalmer No. 5039

P. O. Address 6 St Louis Ave.

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.