

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9458 **63-038098**
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9458

FILED SEP 26 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
1								
2 <u>22</u>								
3								
4 <u>3</u>								
5 <u>2</u>								
6								
7 <u>0</u>								
8 <u>2</u>								
9								
10								
11								
12 <u>75-0</u>								
13								
<u>75</u>								

H. Nour, M.D.
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. No. 1</u>		d. STREETS ADDRESS <u>111 Armstrong</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELZADA</u> Middle _____ Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1898</u>
9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and state or country) <u>St. Louis Mo U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY _____	
13a. FATHER'S NAME <u>Issam Stanley</u>		13b. MOTHER'S MAIDEN NAME <u>Burdie?</u>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give waf or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Fred Stanley</u> Address <u>3910 Kennedy</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>Aspiration pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Metastatic Adenocarcinoma of the uterus - Terminal State.</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>174X</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>9-3-63</u> to <u>9-19-63</u> and last saw her him alive on <u>9-19-63</u> Death occurred at <u>3:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE: <u>H. Nour M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 Lafayette Avenue</u>	
22c. DATE SIGNED <u>9-19-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) _____	23b. DATE <u>9-25-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park St. Louis Co Mo</u>	
23d. LOCATION (City, town, or county) _____		(State) _____	
24. GENERAL DIRECTOR'S ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>SEP 21 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Roan Smith, 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,

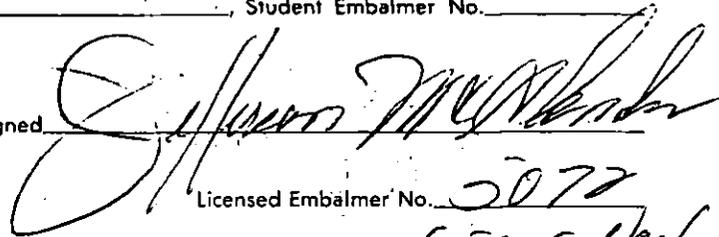
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 5072

P. O. Address 4535 Washington

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.