

Registration District No. 1000 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas Thompson  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. None

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years About 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Wade Thompson  
13. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha Unknown  
15. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bertha Reeder  
(b) Address 1432a Glasgow

17. (a) Burial (b) Date thereof 1-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director E. D. Garner  
(b) Address 2329 Washington, Ave.

19. (a) JAN 11 1940 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2928 Cass, Ave. 21  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. No Physician in Attendance years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 6th  
year 1940 hour 2:15 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage  
Due to J. J. (Hypertension)  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 4  
23. Signature Joseph M. ...  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

William C. McDowell, Registered Apprentice No. ....  
working under my personal supervision.

Signed W C McDowell

Licensed Embalmer No. 2114

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 this body is not embalmed, above space should be left blank.**