

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34021**
Registrar's No. **8718**

Registration District No. **791** Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 16 1940

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Deaconess Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **36 years**
years, months or days)

3. (a) PRINT FULL NAME **Anna Thixton**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **488-03-9582**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 12, 1877**
(Month) (Day) (Year)

8. AGE: Years **63** Months **7** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Owensburg, Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife Power Machine operator**

11. Industry or business _____

12. Name **John L. Thixton**

13. Birthplace **Owensburg, Ky.**
(City, town, or county) (State or foreign country)

14. Maiden name **Susan Bishop**

15. Birthplace **St. Joseph, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rilla Thixton**
(b) Address **4568 N. Market St**

17. (a) Burial _____ (b) Date thereof **10/23/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Marcus Cem.**

18. (a) Signature of funeral director **W. W. McLaughlin**
(b) Address **2301 Lafayette Ave**

19. (a) **OCT 23 1940** (b) **J. F. Berick**
(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. **4568 N. Market St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **21**
year **1940** hour **4** minute **A.** M.

21. I hereby certify that I attended the deceased from **Oct 17/40**, 19____, to **Oct 21/40**, 19____;
that I last saw her alive on **Oct 20/40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death, **in coma and with convulsions**

Due to **injury - head**

Due to _____

Other conditions **hyp. H.P. arteriosclerosis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**

Of autopsy **none**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **accidental**

(b) Date of occurrence **1 week previous**

(c) Where did injury occur? **shop**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
19 on street
(Specify type of place) (e) Means of injury **stumbled**

23. Signature **J. F. Berick** (M. D. or other)
Address **607-71 Grand** Date signed **10/22/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed L. R. Cooper
Licensed Embalmer No. 3633
P. O. Address 2317 Lafayette

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, fact should be so stated above.