

No. 2
M-5-43
5-17-39
X3687

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39862

State File No. _____
Registrar's No. 11688

FILED JAN 11 1946
318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME William Thomas
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced UNKNOWN
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)
8. AGE: about 60 Years Months Days
Unknown
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Peaches
(b) Address Clinton Mo.

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 1 3 45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director Wm. J. Bredeck
(b) Address 9222 Rockaway Rd. Overland Mo.

19. (a) JAN 2 1946 (Date registered) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 116
(c) City or town Ballwin (If outside city or town limits, write "RURAL")
(d) Street No. One Crest Nursing Home (If rural, give location)
(e) Citizen of foreign country? NR (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 28th
year 1945 hour 9:05 minute A M.
21. I hereby certify that I attended the deceased from 11/3/45
_____, 19____, to 12/28/45, 19____;
that I last saw h im alive on 12/28/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Psychosis due to Syphilis, ~~and meningitis~~
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 309

Major findings:
Of operations _____
Of autopsy _____

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) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)
23. Signature R. L. Stubbs, M.D. (M. D. or other)
Address City Hospital Date signed 1-30-45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

[Handwritten signature]
[Handwritten signature]

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.....

Licensed Embalmer No.....

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, fact should be so stated above.