

FILED DEC 21 1945  
Registration District No. 318

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 10828

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:  
3838a Blaine Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
in this community \_\_\_\_\_ 20 years  
years, months or days)

3. (a) PRINT FULL NAME WILLIAM A. THURMAN

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex M U 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife Hattie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 10, 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 1  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Hazel Run, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Elevator Operator

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Joshua Thurman  
13. Birthplace Tenn  
(City, town, or county) (State or foreign country)  
14. Maiden name Eleanor League  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Reese  
(b) Address 3838a Blaine Avenue  
17. (a) Burial (b) Date thereof 12-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery  
18. (a) Signature of funeral director J. F. Bruders  
(b) Address 2301 Lafayette Avenue  
19. (a) DEC 12 1945 (Date received from 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. 3838a Blaine Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11  
year 1945 hour 11:00 minute \_\_\_\_\_ A.M.  
21. I hereby certify that I attended the deceased from Dec 10  
9:30 AM 1945 to Dec 11 1945  
that I last saw him alive on Dec 10 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure, acute Duration Terminal  
Chronic Myocarditis year  
Due to Senility  
Due to \_\_\_\_\_  
Other conditions Malnutrition  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
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 \_\_\_\_\_  
23. Signature John Crowe (M.D. or other)  
Address 3867 Lafayette Date signed 12/14/45  
St. Louis, Mo.

**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. Casper

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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**