DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 43033

FILED DEC 17 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10360

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

**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: 0
Christian Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 hrs. (Specify whether
In this community
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 7 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5705 Era Ave 7
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Thomas

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased December (Month) 3 (Day) 1946 (Year)

8. AGE: Years | Months | Days | If less than one day 13 hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Owen J. Thomas
13. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Hazel Koster
15. Birthplace St. Charles County (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Owen J. Thomas
(b) Address 5705 Era Ave

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec (Month) 5 (Day) 1946 (Year)
(c) Place: burial or cremation Troy, Mo.

18. (a) Signature of funeral director Shepard Funeral Home
(b) Address 1167 Hamilton Ave

19. (a) 12-4-1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 4
year 1946 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 2 - 46, 19 to Dec. 4 - 1946;
that I last saw him alive on Dec. 3 - 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature.

Due to Cesarian Del.

Due to Colonfisis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature T Rhyars (M. D. ~~or other~~)

Address 607 N. Grand Bl. Date signed 12-6-46

(Licensed Embalmer's Statement on Reverse Side)

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

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