

FILED JAN 7 1947

318

State File No.

11195

Registration District No.

Primary Registration District No.

1003

Registrar's 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:
Infirmiry Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7/23/46 to
12/27/46 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Oswald Payne Thomas

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

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased July, 27th 1903
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
43 5 0 hr. min.9. Birthplace Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business _____

12. Name William Thomas Payne13. Birthplace Tennessee
(City, town, or county) (State or foreign country)14. Maiden name Mary15. Birthplace Tennessee
(City, town, or county) (State or foreign country)16. (a) Informant City Infirmiry Records(b) Address 5800 Arsenal St.17. (a) Burial (b) Date thereof 12-30-46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenwood Cemetery18. (a) Signature of funeral director Atkins Bro. Halls(b) Address 3644 Quincy Ave.19. (a) DEC 29 1946 (b) F. Brodick
(Date received local report) (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. 4042 Cook
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27
year 1946 hour 11 minute A M.21. I hereby certify that I attended the deceased from 7/23
12/27, 19 46
that I last saw him alive on 12/27, 19 46
and that death occurred on the date and hour stated above.Immediate cause of death Cerebro Vascular
Accident (1st.)
(2Nd.)

Duration

3-1946
12-24-46Due to Cardio vascular disease,
Several years.

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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) Means of injury _____

23. Signature Palmer P. Powell (M. D. or other) _____

Address _____

Date signed _____

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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 Rowan J. Roth
Licensed Embalmer No. 2847
P. O. Address 3644 Fenwick

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.