

No. 2  
-12-45  
5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **3201**  
Registrar's No. **1064**

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Lamar Thomas  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Col  
6. (a) Single, widowed, married, divorced child  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 7, 1947  
(Month) (Day) (Year)

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

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_  
12. Name William Thomas  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Canary McDonald  
15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant William Thomas  
(b) Address 1405 N. Leffingwell Ave.  
17. (a) Burial (b) Date thereof 2-1-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director C. P. Council  
(b) Address 1221 N. Grand Blvd.  
19. (a) JAN 31 1947 (b) J. F. Bredeck  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 2117  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1405 N Leffingwell  
(If rural, give location) ?  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30  
year 1947 hour 12 minute 45 P M.  
21. I hereby certify that I attended the deceased from 1-22, 1947 to 1-30, 1947;  
that I last saw him alive on Jan. 30, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis and Diarrhea Duration Undet.  
Simple "  
Due to 119a  
Due to \_\_\_\_\_  
Other conditions Malnutrition - Dehydration  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy No  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature Theodore Shriver (Physician or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed 1/31/47

---

---

**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. 3522

P. O. Address..... 3506 Franklin

**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.**