V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36494

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2284

96
2
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis 96
(c) City or town ~~St. Louis County, Valley Pk~~
(If outside city or town limits, write "RURAL")
(d) Street No. Larkin-William Rd Valley Pk 16
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country 1

3. (a) PRINT FULL NAME Albert Thompson,
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Myrtle
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased June 14, 1886
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
61	4	18	hr. min.

9. Birthplace Bloomington, Ill.
(City, town, or county) (State or foreign country)
10. Usual occupation Cement finisher,
11. Industry or business
FATHER
12. Name unknown
13. Birthplace do 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name do
15. Birthplace do 9
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Myrtle Thompson,
(b) Address Larkin-William Rd Valley Pk.
17. (a) burial (b) Date thereof 10/24/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus
18. (a) Signature of funeral director Oscar J Hoffmeister
(b) Address 4016 Chippewa,
19. (a) 10-31-47 (b) Cecil A. Shaw MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 22 day
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Hypertrophy & dilatation	10 yrs? 1 day?
Due to	
Due to 95	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy as above	

PHYSICIAN
Underline the cause of 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 Cecil A. Shaw (M. D. or other)
Address Commissioner of Health Date signed 10-23-47

Jefferson City Printing Co. (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 John S. Demsky

Licensed Embalmer No. 4194

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.