

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7258**

Registrar's No. **378**

FILED FEB 24 1948

Registration District No. **217**

Primary Registration District No. **3063**

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Clayton  
(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 80 min.  
(Specify whether years, months or days)  
 In this community 58 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 9541 Old Bonhomme  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EMIL THOMASSEN

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W  
 6. (b) Name of husband or wife Maryann Mueller 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 30 1889  
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Creve Couer, Mo. U  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer  
 11. Industry or business U. City Park Board

12. Name John Thomassen  
 13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Hortense ?  
 15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Thomassen - son  
 (b) Address 9541 Bonhomme Rd.

17. (a) Burial (b) Date thereof 2/9/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Mallica, Cal.

18. (a) Signature of funeral director Baumman Bros Inc  
 (b) Address 2504 Woodlea Rd. Overland

19. 2-9-48 (b) Cecil A. Sharp  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5 year 1948 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from 2:55 PM Feb. 5 to 3:15 PM Feb. 5 and that death occurred on the date and hour stated above.  
 that I last saw him alive on Feb. 5 19 48  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured myocardium  
 Due to myocardial infarct  
6 to 10 days duration  
 Due to 932

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy hemopericardium with cardiac tamponade

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) \_\_\_\_\_  
 23. Signature Russell Hedner (M. D. or other) \_\_\_\_\_  
 Address St. Louis Co Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

**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 3454

..... Registered Apprentice No. ....  
working under my personal supervision.

Signed David C. Gibson  
Licensed Embalmer No. 3454  
P. O. Address Overland 749

**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.

Registration District No. 317 Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Emil Thomassen

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 30 1880  
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. 2-9-48 (Date received local registrar) (b) Carl R. [Signature] (Registered Registrar)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

7258