

S. No. 300  
M-1047  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10751  
3139

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED APR 7 1948  
Registration District No. 218

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(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: KENROUTE TO CITY 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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State ILLINOIS (b) County ST. CLAIR  
(c) City or town EAST ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2323 ON 54th Street  
W.R. (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM LAWSON THOMPSON  
(b) If veteran, name war World War I  
3. (c) Social Security No. 355-01-0568

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 30  
year 1948 hour 8 minute 40 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife ANNA THOMPSON  
6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased APRIL 26 1895  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 52 Months 11 Days 4  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FOUNDRY WORKER

11. Industry or business FOUNDRY

12. Name LAWSON THOMPSON  
13. Birthplace SALEM Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name PAUCY MITCHELL  
15. Birthplace SALEM Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant ANNA THOMPSON  
(b) Address 5 St. Louis, Ill.

17. (a) Burial (b) Date thereof Apr. 3, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Hope - Salem, Mo.

18. (a) Signature of funeral director J. F. Bredek  
(b) Address 1111 E. St. Louis, Ill.

19. (a) MAR 31 1948 (b) J. F. Bredek  
(Date received from registrar) (Registrar's signature)

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) (e) Means of injury 3  
23. Signature Wm. E. Doyle (M. D. or other)  
Address 1111 E. St. Louis, Ill. Date signed 3/31/48

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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.....

*That Embalmed*, Registered Apprentice No.....  
working under my personal supervision.

Signed.....  
*Joseph J. Karsky*  
Licensed Embalmer No. *75241 - Ill.*  
P. O. Address.....  
*St. Louis, Ill.*

**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.**