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FEDERAL BUREAU OF VITAL STATISTICS
National Office of Vital Statistics
FILED JUL 5 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21394
Registrar's No. 5830

Registration District No. 318

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Vera Lee Thigpen
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex Fem. 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation Infant

11. Industry or business.....

MOTHER FATHER

12. Name John Thigpen

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

14. Maiden name Vera Lee Carter

15. Birthplace Gadi Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel M. Howard, R.N.
(b) Address 2601 N. Whittier

17. (a) Anatomical Board (b) Date thereof JUN 20 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Anatomical Board Rowland Mortuary Service

18. (a) Signature of funeral director 4104 Manchester Ave.
(b) Address

19. (a) JUN 20 1948 J. F. Berdeck
(Date received local registration) (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. 424 S. Garrison
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 2
year 1948 hour 12 minute 45 A.M.
21. I hereby certify that I attended the deceased from 6:20 P.M.
5-28-, 1948, to 12:45 A.M., 1948
that I last saw her alive on 6-2-, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration

Due to.....
Due to.....
Other conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
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 W. H. Jenkins (M. D. or other)
Address 2601 N. Whittier 6-2-48
Date signed

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.....

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.