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U.S. DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21400  
State File No. \_\_\_\_\_  
Registrar's No. 5375

FILED JUN 21 1948  
218

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

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis  
(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 23 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 25 1232 Agee Court 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sam Thurman

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

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years abt. 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace West. Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

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

12. Name Sam Thurman, Sr.

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

14. Maiden name Unknown

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

16. (a) Informant Lincoln Thurman

(b) Address 5140 Sawton Blvd

17. (a) Burial (b) Date thereof 6-14-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Arthur Brown

(b) Address 3644 Franklin Ave

19. (a) 13 1948 (b) J. J. Bedeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10  
year 1948 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from 5-18- 1948 to 6-10 1948;  
that I last saw him alive on June 10 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Prob. Pulmonary Tuberculosis Duration Undet.

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

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

Other conditions None  
(Include pregnancy within 3 months of death)

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

Of autopsy None

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)  
Terms of injury \_\_\_\_\_

23. Signature Osborn J. Daniels (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed 6/11/48

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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.....

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

Signed Louis V. Atkins

Licensed Embalmer No. 28424

P. O. Address 3644 Finney

**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.**