

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14223

State File No. \_\_\_\_\_

318

1003

BIRTH NO. 49-019605 REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. 2884

21

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If rural, give location) <b>2822 Gamble</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) <b>James</b>	b. (Middle) <b>Henry</b>	c. (Last) <b>Thomas</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>3-26-49</b>	
9. AGE (In years last birthday)		10. UNDER 1 YEAR	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Willie Thomas</b>		13b. MOTHER'S MAIDEN NAME <b>Evie Bernice Weaver</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <i>Kathy M. Howard</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		19. ADDRESS <b>2601 N. Whittier</b>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Injury at birth, Intracranial</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Howa</b>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? <b>76lb 0</b>		22. I hereby certify that I attended the deceased from <b>3-26-1949</b> , to <b>3-26-1949</b> , that I last saw the deceased alive on <b>3-26-1949</b> , and that death occurred at <b>4:30p.m.</b> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>W. H. ...</i>		23b. ADDRESS <b>2601 N. Whittier</b>	
23c. DATE SIGNED <b>3-30-49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE <b>APR 30 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Mortuary Service</b> 4104 Manchester Ave.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>APR 30 1949</b> <i>J. B. ...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Mortuary Service</b> 4104 Manchester Ave.	

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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 \_\_\_\_\_

....., **Student Embalmer No.** .....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No. ....

P. O. Address.....

- **Noté:** 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.