

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35836

FILED OCT 19 1949

State File No. \_\_\_\_\_  
Registrar's No. 4081

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>4081</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Berkeley</u>		c. LENGTH OF STAY (In this place) <u>4 year</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Berkeley</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1st &amp; Garfield</u>				d. STREET ADDRESS (If rural, give location) <u>1st &amp; Garfield</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nina</u>			b. (Middle) <u>Smith</u>		c. (Last) <u>Thompson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10/3/49</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Married</u> (Specify)		8. DATE OF BIRTH <u>Aug. 26, 1949</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Palmyra, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Byron Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Agnes Loper</u>		14. NAME OF HUSBAND OR WIFE <u>William H. Thompson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W. H. Thompson, Berkeley, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myasthenia gravis</u>  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. <u>Arteriosclerosis generalized 10 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>  <u>7440</u>
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-26</u> , 1949, to <u>10-3</u> , 1949, that I last saw the deceased alive on <u>10-3</u> , 1949, and that death occurred at <u>10:26 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Mitchell D. Johnson M.D.</u>				23b. ADDRESS <u>Ferguson, Mo</u>		23c. DATE SIGNED <u>10-5-1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10/6/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Des Moines, Iowa.</u>		
DATE REC'D BY LOCAL REG. <u>10-6-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dumble</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>White Funeral Home, Ferguson, Mo.</u>			

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

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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.

Student .....  
Student Embalmer

Signed L. M. White

Licensed Embalmer No. 3973

P. O. Address Jerguson, Mo

**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.