

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39364

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9782**

1. PLACE OF DEATH: a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital		d. STREET ADDRESS (If rural, give location) 23- 1325 S. 6th 0	

3. NAME OF DECEASED (Type or Print) a. (First) Wren b. (Middle) c. (Last) Thompson			4. DATE OF DEATH (Month) (Day) (Year) 11-10-49		
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 5, 1900	9. AGE (In years last birthday) 49	10. MONTHS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY General Practice	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Samuel Thompson		13b. MOTHER'S MAIDEN NAME Sarah Meyers		14. NAME OF HUSBAND OR WIFE Minnie Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 489129989		17. INFORMANT'S SIGNATURE OR NAME Minnie Thompson ADDRESS 1325 S. 6th	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subsidiary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) bilateral, Tubercular			
		DUE TO (c) left supra renal gland			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 10	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **140 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph M. ... (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 11/12/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11-14-49		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. NOV 14 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Fendler Undtk. Co. ADDRESS m7420 Michigan	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 VE Morris

Licensed Embalmer No. 3360

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.