

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25339
6153

State File No.
Registrar's No.

BIRTH NO. 45819-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 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 township) St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | |
| c. LENGTH OF STAY (In this place) 2 days | | 2229 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips | | d. STREET ADDRESS (If rural, give location) 2214 Spruce | |
| 3. NAME OF DECEASED (Type or Print) Frank | | a. (First) | b. (Middle) |
| c. (Last) Thomas | | 4. DATE OF DEATH (Month) (Day) (Year) 7 9 50 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0 | 8. DATE OF BIRTH 7-7-50 |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR Months 2 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY? | | 13a. FATHER'S NAME Tom Thomas | |
| 13b. MOTHER'S MAIDEN NAME Essie Smith | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT'S SIGNATURE OR NAME <i>Walter M. Howard</i> | | ADDRESS RRL 2601 N. Whittier | |
| 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) Asphyxia Pallida 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) _____ DUE TO (c) _____ 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 type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT (Specify) SUICIDE HOMICIDE | | 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) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? 762.5 | | | |
| 22. I hereby certify that I attended the deceased from 7-7-1950 , to 7-9-1950 , that I last saw the deceased alive on 7-9-1950 , and that death occurred at 5:00a m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE <i>W. B. Fisher</i> | | 23b. ADDRESS 2601 N. Whittier | |
| 23c. DATE SIGNED 7-11-50 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 6 JUL 18 1950 | |
| 24c. NAME OF CEMETERY OR CREMATORY Anderson Bury | | 24d. LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REG. JUL 18 1950 | | REGISTRAR'S SIGNATURE <i>J. B. Foster</i> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Svc. | | ADDRESS 4104 06 Manchester | |

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

X Howard

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

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.