No. 300
10-48

FILED JUN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18676

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5066

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PEOPLES HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 2219
d. STREET ADDRESS (If rural, give location): 2109 COLE ST. O

3. NAME OF DECEASED (Type or Print)
a. (First): IDA
b. (Middle):
c. (Last): THOMPSON

4. DATE OF DEATH (Month) (Day) (Year): MAY 28 1951

5. SEX: FEMALE 3
6. COLOR OR RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 1
8. DATE OF BIRTH: APR. 9, 1883
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): ABERDINE / MISS.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: FLEM VANCE
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: SAM THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: SAM THOMPSON — ADDRESS: 2109 COLE ST.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Myocarditis

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 ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NO
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 422.2

22. *I hereby certify that I attended the deceased from* July, 1950, *to* May 28, 1951, *that I last saw the deceased alive on* May 28, 1951, *and that death occurred at* 6:40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Blair W. Carter M.D.
23b. ADDRESS: 2425 Biddle
23c. DATE SIGNED: 5/31/51

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: JUNE 4, 1951
24c. NAME OF CEMETERY OR CREMATORY: WASHINGTON PARK CEM.
24d. LOCATION (City, town, or county) (State): ~~BERKLEY~~ St. Louis Co. MO

DATE REC'D BY LOCAL REG.: JUN 1 1951
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE: Mose Vossar — ADDRESS: 2812 CASS AVE

(Licensed Embalmer's Statement on Reverse Side)

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 .....

a ....., ~~Student Embalmer No.~~ .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Leroy U. Barnister

Licensed Embalmer No. 4523

P. O. Address 3880 Eastern Av

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.