

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3407

State File No.

FILED FEB 14 1952

Registrar's No. 0902

BIRTH NO. _____ 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 town) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 23 2500 South Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) IDA	b. (Middle)	c. (Last) THOMPSON	DEATH JAN. 11 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 3, 1875
9. AGE (In years last birthday) 76		10. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Kansas
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OA		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Bair	13b. MOTHER'S MAIDEN NAME Nancy Young	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Hospital Record	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 16 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumococcal Pneumonia		
	ANTECEDENT CAUSES Morbidity 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. Latent syphilis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? H93XB
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22. I hereby certify that I attended the deceased from 12-29-51, 19__, to 1-11-52, 19__, that I last saw the deceased alive on 1-11-52, 19__, and that death occurred at 10:20Pm., from the causes and on the date stated above.

23a. SIGNATURE George M. Workman M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 1-18-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) In	24b. DATE 1-31-52	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JAN 30 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S NAME AND ADDRESS Rowland Mortuary Service 4104 Manchester Ave.
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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.....
.....
working under my personal supervision. Student Embalmer No.....

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.