

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6820**

FILED MAR 5 1952 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1274**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 5062 No. Union Blv.	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) W c. (Last) THOMPSON Sr.		4. DATE OF DEATH (Month) (Day) (Year) FEB. 8, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4/27/1868
9. AGE (In years last birthday) 83 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unk.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Thompson		13b. MOTHER'S MAIDEN NAME Elizabeth Leaber	
14. NAME OF HUSBAND OR WIFE Caroline		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. 491-12-9227		17. INFORMANT'S SIGNATURE OR NAME Wm. Thompson Jr. 5062 No. Union	
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) Pulmonary tuberculosis, fatal INTERVAL BETWEEN ONSET AND DEATH 5+ years 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. Chronic cor pulmonale	
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)	
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? PO2X	
22. I hereby certify that I attended the deceased from 2-2-52 , 19___, to 2-8-52 , 19___, that I last saw the deceased alive on 2-8-52 , 19___, and that death occurred at 8:35A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Andrew L. Harlan M.D.		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 2-8-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/11/52	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 9 1952	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith M.D.		ADDRESS 2228 Lafayette Ave.

(Licensed Embalmer's Statement on Reverse Side)

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.....

John B. Holman

Signed.....
Student Embalmer

Licensed Embalmer No. *4914*

P. O. Address *3125 Lafayette*

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.