

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **37655**
Registrar's No. **9928**

FILED OCT 29 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Union	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Anna	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pacific Hosptl.		d. STREET ADDRESS (If rural, give location) 205 Grove Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) William c. (Last) Thompson			4. DATE OF DEATH (Month) (Day) (Year) Oct. 16 1953		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May -1, 1893		9. AGE (In years last birthday) 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mantce. On Rld.		10b. KIND OF BUSINESS OR INDUSTRY G.M.N.O.Rld. Co.		11. BIRTHPLACE (State or foreign country) Pamona, Ill.	
12. CITIZEN OF WHAT COUNTRY? USA.					

13a. FATHER'S NAME Richard Thompson	13b. MOTHER'S MAIDEN NAME Eliza Thompson	14. NAME OF HUSBAND OR WIFE Hattie Thompson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY (If yes, give war or dates of service) 718-10-4070	17. INFORMANT'S SIGNATURE OR NAME Mrs Hattie Thompson 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary artery insufficiency 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 checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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22. I hereby certify that I attended the deceased from 10. 7., 1953, to 10. 16., 1953, that I last saw the deceased alive on 10. 16., 1953, and that death occurred at 9:15 P m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) MD	23b. ADDRESS [Address]	23c. DATE SIGNED 10-17-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) 10/19/53	24b. DATE 10/19/53	24c. NAME OF CEMETERY OR CREMATORY Local Cemetery	24d. LOCATION (City, town, or county) (State) Anna - Union Co Ill
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DATE REC'D BY LOCAL REG. OCT 19 1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS St. Louis Ill
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 23 1953

2126

MAR 17 1954

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.....

[Handwritten Signature]

Signed.....
Student Embalmer

Not Embalmed

Licensed Embalmer No. 2162

P. O. Address. East St Louis Ill

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.