

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3358**
Registrar's No. **0633**

FILED FEB 2 1954

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

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY OR TOWN St. Louis Mo		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		e. STREET ADDRESS (If rural give location) 5319 Easton 2067	

3. NAME OF DECEASED (First) John (Middle) A. (Last) Tompkins			4. DATE OF DEATH (Month) (Day) (Year) Jan. 19-1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Sept 4-1872		9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Black Clerk	
11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY? _____			

13a. FATHER'S NAME Abraham Tompkins		13b. MOTHER'S MAIDEN NAME Emma - Antunow		14. NAME OF HUSBAND OR WIFE Catherine Tompkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) No.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Viola R. Echols ADDRESS 3700 So. Jefferson	

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) Acute cardiac failure			INTERVAL BETWEEN ONSET AND DEATH 4 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General arteriosclerosis			3 yrs
		DUE TO (c) Bronchiectasis			1 1/2 yrs
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Asthma bronchial			3 yrs
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from **Sept 3, 1878** to **1/19/54**, that I last saw the deceased alive on **1/19, 1954**, and that death occurred at **7 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. J. Mustachek MD		23b. ADDRESS 2903 Olive		23c. DATE SIGNED 1/20/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/22/54		24c. NAME OF CEMETERY OR CREMATORY St. Marys Church Cemetery	
				24d. LOCATION (City, town, or county) (State) Acton, Ill	

DATE REC'D BY LOCAL REG. JAN 21 1954		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Bensiek-Nicholas Morticians ADDRESS 1431 Union St	
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Paul A. Wachter*.....

Licensed Embalmer No. *476*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.