

FILED APR 21 1954

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14185

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3144

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 3016 Walton	

3. NAME OF DECEASED (Type or Print) WESLEY (First) (NMI) (Middle) THURMAN (Last)			4. DATE OF DEATH (Month) (Day) (Year) APRIL 5, 1954		
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 31, 1915		9. AGE (In years last birthday) 38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Core Maker		10b. KIND OF BUSINESS OR INDUSTRY Scullins Steel		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	

13a. FATHER'S NAME Wesley Thurman		13b. MOTHER'S MAIDEN NAME Willie Bailey		14. NAME OF HUSBAND OR WIFE Cleora Thurman	
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. 487 18 6949		17. INFORMANT'S SIGNATURE OR NAME Cleora Thurman	
				ADDRESS 3016 Walton	

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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		ANTECEDENT CAUSES DUE TO (b) Malignant Hypertension		2 yrs.	
		DUE TO (c) Arteriosclerotic Heart Disease			
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"/>	
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) 331X	
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 3-19-1954, to 4-6-1954, that I last saw the deceased alive on 4-6-1954, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

23a. SIGNATURE FR Bradley		(Degree or title) M. D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 4-6-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 12, 1954		24c. NAME OF CEMETERY OR CREMATORY Greenwood		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	

DATE REC'D BY LOCAL REG. APR 7 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE E. B. Koovey		ADDRESS 1221 N. Grand	
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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 *Gayton Swan*.....

Licensed Embalmer No. *458*.....

P. O. Address *1221 N. 1st*.....

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.