

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7296**

**318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **1294**

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. <b>1294</b>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Illinois</b> b. COUNTY <b>Jefferson</b> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>   |  | c. LENGTH OF STAY (In this place) _____   |  | c. CITY OR TOWN <b>Bluford</b>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>   |  |   |  | e. STREET ADDRESS (If rural, give location) _____   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Ramona</b>  |  | b. (Middle) <b>Deane</b>  |  | c. (Last) <b>Thomason</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Feb. 3, 1956</b>  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   |  | 8. DATE OF BIRTH <b>March 8, 1930</b>   |  |
| 9. AGE (In years last birthday) <b>25</b>  |  | IF UNDER 1 YEAR Months _____ Days _____   |  | IF UNDER 24 HRS. Hours _____ Min. _____   |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Bluford, Illinois</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>  |  |
| 13a. FATHER'S NAME <b>Keith Lowry</b>  |  |   | 13b. MOTHER'S MAIDEN NAME <b>Esther Offenstein</b> |   |  | 14. NAME OF HUSBAND OR WIFE <b>Norman Thomason</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Norman Thomason, Bluford, Ill.</b>   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                                 |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cranio-pharyngioma</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>224X</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>   |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |   |  | 20. AUTOPSY?<br>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) _____  |  | 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 <b>Jan. 12, 1956</b> , to <b>Feb. 3, 1956</b> , that I last saw the deceased alive on <b>Feb. 3, 1956</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. |  |   |  |   |  |   |  |
| 23a. SIGNATURE <b>C. J. Millin, M.D.</b> (Degree or title) <b>M. D.</b>  |  |   |  | 23b. ADDRESS <b>BARNES HOSPITAL</b>   |  | 23c. DATE SIGNED <b>2/4/56</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |  | 24b. DATE <b>2-4-56</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Hickory Hill</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>Jefferson County, Ill.</b>   |  |
| DATE REC'D BY LOCAL REG. <b>FEB 6 1956</b>   |  | REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoopes, 4700 Washington</b>   |  |   |  |

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

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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 *E. Ross K. Gardwell* .....

Licensed Embalmer No. *407* .....

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.