. Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 15371

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4009

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 32 St. Luke's — Length of stay in 1b 1 Week

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY Saline
c. CITY OR TOWN Harrisburg 612 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 32 402 N. Webster — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Anthony Middle D. Last Thompson

4. DATE OF DEATH Month April Day 21 Year 1957

5. SEX Male 0

6. COLOR OR RACE White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 4-23-1898

9. AGE (In years last birthday) 58

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Contractor

10b. KIND OF BUSINESS OR INDUSTRY Self Employed

11. BIRTHPLACE (City and state or country) Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Phillip Thompson

14. MOTHER'S MAIDEN NAME Rose Ann Armor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W I

16. SOCIAL SECURITY NO. 356-10-9045

17. INFORMANT Mrs Ella May Thompson Address Harrisburg Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 434.3

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4/18 to death and last saw her/him alive on 4/25/57
Death occurred at 3:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Cyril M. MacDougall (Degree or title) M.D.

22b. ADDRESS 634 N. Grand St. Louis

22c. DATE SIGNED 4/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 4-26-57

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) Harrisburg (State) Ill.

24. FUNERAL DIRECTOR Gaskins ADDRESS Harrisburg, Ill.

25. DATE RECD. BY LOCAL REG. APR 26 '57

26. REGISTRAR'S SIGNATURE Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Frank Prokopf

Licensed Embalmer No. 43

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.