

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016089

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1222

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE, (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u> OR TOWN <u>St. Louis County</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Elmwood 4000</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County</u>		Length of stay in lb <u>24 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>9624 Reble St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clause</u> Middle <u>Thomas</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1894</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hod Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various Const. Co</u>	11. BIRTHPLACE (City and state or country) <u>Gardenville, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	

13a. FATHER'S NAME <u>Dick Thomas</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>Henrietta Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>198-03-1780</u>	17. INFORMANT (Full name and address) <u>Etta Thomas 9624 Reble St</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Perforation of esophagus</u>			
	DUE TO (c) <u>Carcinoma of esophagus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>150X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.				

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>4-8-59</u> to <u>5-4-59</u> and last saw her/him alive on <u>5-4-59</u> Death occurred at <u>7:30</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Vincent J. Fiedrich MD</u>	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo</u>	22c. DATE SIGNED <u>5-4-59</u>
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23a. BURIAL OR CREMATION <u>Funeral</u>	23b. DATE <u>5/8/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo</u>
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24. FUNERAL DIRECTOR <u>C.W. Roberts Mod. Co</u>	ADDRESS <u>1416 N. Taylor</u>	25. DATE RECD. BY LOCAL REG. <u>5-4-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *James L. Carter*

Licensed Embalmer No. *44681*

P. O. Address *2902*

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.