

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
EILED VS MAY 18 1960

=60-021622

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4636** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY None		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY None	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hosp		d. STREET ADDRESS (If outside, give location) 4853 Page Blvd.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Alice Middle THOMPSON Last THOMPSON			4. DATE OF DEATH Month April Day 29 Year 1960		
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5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/6/78	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) E. St. Louis, Ill.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Slyvester Merryman	13b. MOTHER'S MAIDEN NAME Nancy Mitchell	14. NAME OF HUSBAND OR WIFE
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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. -----	17. INFORMANT Jessie Riley, 4853 Page Blvd.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Fractured Neck of Femur Aortic Stenosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Aortic Stenosis DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. 904.0 2A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Suffered when deceased fell	
20c. TIME OF INJURY Hour 4:25 a.m. 6 p.m. Month, Day, Year at home on April 25, 1960	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.) at home	20f. CITY, TOWN, OR LOCATION St. Louis Mo.

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at **9:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ray M. Quisenberry	(Degree or title) Dep Cor	22b. ADDRESS 1300 Clark Avenue	22c. DATE SIGNED 5-2-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-3-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis 15, Mo.
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24. FUNERAL DIRECTOR Metropolitan Funeral System	ADDRESS 5010 Enright Ave	25. DATE RECD. BY LOCAL REG. MAY 2 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION

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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 _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John Cunningham
4476

Licensed Embalmer No. _____

P. O. Address _____ 2405 Marcus

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