

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 3 Days	c. CITY OR TOWN Bonne Terre
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 518 Grove, St.

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	GEORGE	WILLIAM	THOMURE		Nov.	25,	1960

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1876	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
----------------	---------------------------	---	------------------------------	------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump Man	10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Lead Co.	11. BIRTHPLACE (City and state or country) St. Genevieve, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	--	---------------------------------------

13a. FATHER'S NAME Damien Thomure	13b. MOTHER'S MAIDEN NAME Rosine LaRose	14. NAME OF HUSBAND OR WIFE Nannie
--------------------------------------	--	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> No	16. SOCIAL SECURITY NO. 497-05-4383	17. INFORMANT Mrs. James Pratt, Bonne Terre, Mo.	Address
---	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial Infarction		2 days
DUE TO (b) Arteriosclerotic Heart Disease		years
DUE TO (c) 420' OF		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inter-trochanteric fracture right femur hip	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) Fall out of bed at nursing home at Bonne Terre, Mo 11-20-60
---	--	---

20c. TIME OF INJURY Hour a.m. 11-20-60	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 655 Nursing Home	20f. CITY, TOWN, OR LOCATION Bonne Terre	COUNTY	STATE Mo.
---	---	--	---	--------	--------------

21. I attended the deceased from Nov. 21, 1960 to Nov. 25, 1960 and last saw him alive on Nov. 25, 1960	Death occurred at 3:30 P.M.	on the date stated above, and to the best of my knowledge, from the causes stated.
--	--------------------------------	--

22a. SIGNATURE (Degree or title) F. R. Bradley, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 11/25/60
---	---------------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-27-60	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City, town, or county) St. Francois County, Mo.	(State)
--	-----------------------	--	---	---------

24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. NOV 28 1960	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OK Right in the conditions, if any, which gave rise to above cause (a), starting the underlying cause last.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kable

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

IMPORTANT REMARKS:

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.