

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		Length of stay in 1b		c. CITY OR TOWN Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homert G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 218 Hill St.	
				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Jim Middle Last Thurman			4. DATE OF DEATH Month 11 Day 9 Year 60			
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1899	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days	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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (City and state or country) Rankin Co., Miss		12. CITIZEN OF WHAT COUNTRY USA	
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13a. FATHER'S NAME Jake Thurman		13b. MOTHER'S MAIDEN NAME Annie Mitchel		14. NAME OF HUSBAND OR WIFE Silvia Thurman	
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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. 431-16-6311		17. INFORMANT Silvia Thurman-218 Hill St., Madison, Ill.	
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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:			INTERVAL BETWEEN ONSET AND DEATH undet.
IMMEDIATE CAUSE (a) Carcinoma of the Thyroid			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) 1941			
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. <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 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.)		
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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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	
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21. I attended the deceased from **10-6-60** to **11-9-60** and last saw ^{her}him **11-9-60**
Death occurred at **8:45** a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>J. O. Richards, M.D.</i>		22b. ADDRESS 2601 N. Whittier Ave.		22c. DATE SIGNED 11-10-60	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/12/60	23c. NAME OF CEMETERY OR CREMATORY East St. Louis, Illinois		23d. LOCATION (City, town, or county) (State)	
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24. FUNERAL DIRECTOR ADDRESS Marshall Funeral Home-East St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. NOV 12 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Thomas M. Alshab

Licensed Embalmer No. 4479

P. O. Address East St. Louis,

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.