

PART DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047995

9 1961
INDEXED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12232 STATE FILE NUMBER

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 St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4350 Cote Brillante
3. NAME OF DECEASED (Type or print) First Jessie Middle Thompson Last			4. DATE OF DEATH Month 12 Day 17 Year 60		
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 11-5-82	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Johnson		13b. MOTHER'S MAIDEN NAME Divernion		14. NAME OF HUSBAND OR WIFE	
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 Address James Thompson-4436 Aldine		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with Intestinal Obstruction with Metastasis		INTERVAL BETWEEN ONSET AND DEATH Undet.
DUE TO (b)		
DUE TO (c) 153-8		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Edema		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 9-21-60 to 12-17-60 and last saw her ⁶⁰ alive on 12-17-60
Death occurred at 3:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. Phillips</i> (Deputy title)	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 12-19-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-24-60	23c. NAME OF CEMETERY OR CREMATORY Father Dickson	23d. LOCATION (City, town, or county) (State) Kirkwood, Mo.
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24. FUNERAL DIRECTOR A.L. Beal Und.Co.-4303 Delmar	25. DATE RECD. BY LOCAL REG. DEC 21 1960.	26. REGISTRAR'S SIGNATURE <i>Loan 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

Geoffrey Swa

Licensed Embalmer No. 4580

P. O. Address 4107 E.

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.