

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4796-61-019543  
STATE FILE NUMBER

AMENDED FILED JUN 2 1961 318 Primary Registration District No. 1003 Registrar's No. 4796

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1011 Walton</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MABLE</b> Middle <b>NMN</b> Last <b>THOMPSON</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>27 May 1907</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Little Rock Ark</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Willie Walker</b>		13b. MOTHER'S MAIDEN NAME <b>Izetta Mackey</b>		14. NAME OF HUSBAND OR WIFE <b>Eugene Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Gertrude Dennis 1011 Walton</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR HEMORRHAGE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
Conditions; if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>					<b>6 YEARS</b>
DUE TO (c) <b>443x</b>					
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year					
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 <b>MAY 17, 1961</b> to <b>MAY 19, 1961</b> and last saw her/him alive on <b>MAY 19, 1961</b> Death occurred at <b>5:15 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>FR. R. BRADLEY, M. D.</b>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>5/19/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>22 May 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo/</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Reliable Funeral Sys. 1389 N. Union</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 22 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>		

STATE OF MASSACHUSETTS

NAME OF DECEASED      NAME OF OPERATOR      NAME OF LICENSED EMBALMER

**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

*Errence Craems*

Licensed Embalmer No. 4755

P. O. Address 1389 N Union

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.