

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013921

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2800** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAR 28 1963**

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

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MEDICAL CERTIFICATION

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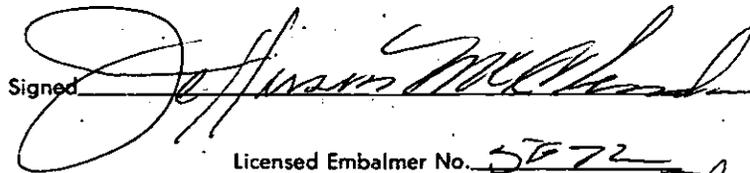
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|   |  |  |  |   |  |   |  |  |  |   |  |                |  |   |  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|----------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN   |  | Length of stay in 1b  |  | c. CITY OR TOWN                               |  | Inside Limits  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  | b. COUNTY      |  | Reside on Farm  |  |  |
|   |  | <b>St. Louis</b>   |  | <b>25 yrs.</b>  |  | <b>St. Louis</b>                              |  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  |  | <b>Mo.</b>  |  | <b>Mo.</b>     |  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |  | D.O.A. Homer G. Phillips   |  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS (if outside, give location) |  | <b>4244 W Ashland Ave.</b>   |  |   |  |                |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)   |  | First  |  | Middle  |  | Last  |  | 4. DATE OF DEATH   |  | Month   |  | Day            |  | Year  |  |  |
|   |  | <b>Dorothy</b>   |  | <b>Leona</b>  |  | <b>Thompson</b>                               |  | <b>March</b>   |  | <b>8</b>  |  | <b>1963</b>    |  |   |  |  |
| 5. SEX  |  | 6. COLOR OR RACE   |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH                              |  | 9. AGE (last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HR |  |   |  |  |
| <b>Female</b>   |  | <b>Negro</b>   |  |   |  | <b>7/5/1916</b>                               |  | <b>46 yrs.</b>   |  | Months  |  | Days           |  | Hours   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)  |  | 12. CITIZEN OF WHAT COUNTRY                   |  |  |  |   |  |                |  |   |  |  |
| <b>Day work</b>   |  | <b>Private family</b>  |  | <b>Lebanan, Missouri</b>  |  | <b>USA</b>                                    |  |  |  |   |  |                |  |   |  |  |
| 13a. FATHER'S NAME  |  |  |  | 13b. MOTHER'S MAIDEN NAME   |  |   |  | 14. NAME OF HUSBAND OR WIFE  |  |   |  |                |  |   |  |  |
| <b>Charles Coffey</b>   |  |  |  | <b>Maude Howard</b>   |  |   |  | <b>Cecil Thompson</b>  |  |   |  |                |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)                                  |  |  |  | 16. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT Address  |  |   |  |                |  |   |  |  |
| <b>no</b>   |  |  |  |   |  |   |  | <b>Cecil Thompson, 4244 W Ashland Ave</b>  |  |   |  |                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:   |  |  |  | IMMEDIATE CAUSE (a)   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                |  |   |  |  |
|   |  |  |  | <b>Cerebral Hemorrhage</b>  |  |   |  |  |  |   |  |                |  |   |  |  |
|   |  |  |  | Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  | DUE TO (b)   |  |   |  |                |  |   |  |  |
|   |  |  |  |   |  |   |  | DUE TO (c)   |  |   |  | <b>331x</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 type="checkbox"/> No <input checked="" 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.)  |  |   |  |  |  |   |  |                |  |   |  |  |
| 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 _____ to _____ and last saw her/him alive on _____   |  | Death occurred at _____ on _____ the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |  |   |  |                |  |   |  |  |
| 22a. SIGNATURE (Degree or title)  |  | 22b. ADDRESS   |  | 22c. DATE SIGNED  |  |   |  |  |  |   |  |                |  |   |  |  |
| <b>[Signature]</b>  |  | <b>1300 Clara</b>  |  | <b>3-11-63</b>  |  |   |  |  |  |   |  |                |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county)         |  |  |  |   |  |                |  |   |  |  |
| <b>Removal</b>  |  | <b>3-14-63</b>   |  | <b>National Cemetery</b>  |  | <b>ST. LOUIS Co. Mo.</b>                      |  |  |  |   |  |                |  |   |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 24. DATE RECD. BY LOCAL REG.  |  | 26. REGISTRAR'S SIGNATURE                     |  |  |  |   |  |                |  |   |  |  |
| <b>W. J. Baker &amp; Son,</b>   |  | <b>3801 N. Newstead</b>  |  | <b>MAR 11 1963</b>  |  | <b>[Signature]</b>                            |  |  |  |   |  |                |  |   |  |  |

**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 

Licensed Embalmer No. 5072

P. O. Address 4535 W. 14th St

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.