

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030590

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7624 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

FILED AUG 1 1963

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 <u>20</u>	
3	
4 <u>3</u>	
5 <u>0</u>	
6	
7 <u>0</u>	
8 <u>1</u>	
9	
10	
11	
12 <u>75-0</u>	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF DOCUMENT

BANNON
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>5335 VERNON</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TINA LOUISE THOMPSON</u>			4. DATE OF DEATH Month Day Year <u>JULY 9, 1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/63</u>
9. AGE (last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min. <u>9:05 36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13a. FATHER'S NAME <u>SAMMIE LEE THOMPSON</u>		13b. MOTHER'S MAIDEN NAME <u>JEANETTE J. JACKSON</u>	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Address <u>ST. LOUIS CITY HOSP. #1.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>NO NO</u>			
16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>7600</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Neonatal Abnormalities</u>			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 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 <u>7/8/63</u> to <u>7/9/63</u> and last saw her/him alive on <u>7/9/63</u> Death occurred at <u>7:05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Carrie E. Bannon, R.D.</u>		22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>7/9/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-31-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Ogden 4106 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 25 1963</u>	26. REGISTRAR'S SIGNATURE <u>Leod Smith, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

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. _____

P. O. Address _____

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.