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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25109

FILED JUL 16 1945

Registration District No. 3/7 — Primary Registration District No. 3066 — Registrar's No. 1754

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
708 Edgewood Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 months (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois 94
(c) City or town Bonne Terre 2
(If outside city or town limits, write "RURAL")
(d) Street No. 43 W. School St. 1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Thomas A. Son

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Ida Son

6. (c) Age of husband or wife if alive years

7. Birth date of deceased January (Month) 2 (Day) 1857 (Year)

8. AGE: Years 88 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Morgan County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Physician

11. Industry or business

FATHER
12. Name James M. Son
13. Birthplace Morgan County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Eliza Harris
15. Birthplace Morgan County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Robert Womack
(b) Address 708 Edgewood Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 7-13-1945 (Date received local registrar) (b) E. J. McGowan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1945 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from June 8, 1945, to July 10, 1945
that I last saw him alive on July 8, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	2 yrs
Due to: Arteriosclerosis	5 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): 938	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature W. H. Kelling (M. D. or other) M.D.
Address 4963 Clemens Date signed 7/14/45

(Licensed Embalmer's Statement on Reverse Side)

MAR 22 1946

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... W W Wilkinson

Licensed Embalmer No..... 3576

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 this body is not embalmed, fact should be so stated above.