CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. City Infirmary St.; 24 Ward)

Registration District No. 791 File No. 39718

Primary Registration District No. 1003 Registered No. 8621

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Theo Thalenhorst

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7 AGE: about 80 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (City or town, State or foreign country): Ger

PARENTS

10 NAME OF FATHER: Chas Thalenhorst

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ger

12 MAIDEN NAME OF MOTHER: Mary Eggemeyer

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ger

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Mulhall

(Address) 5800 Arsenal St

15 Filed SEP 12 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 19 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 16, 1918 to Sept 11, 1918

that I last saw him alive on Sept 11, 1918

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 81 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Sept 11 1918 (Address) City Infirmary

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 5 yrs. 4 mos. 22 ds. In the State 37 yrs. 4 mos. 22 ds.

Where was disease contracted if not at place of death?

Former or usual residence 5800 Arsenal St

19 PLACE OF BURIAL OR REMOVAL: POTTERS FIELD

DATE OF BURIAL: SEP 11 1918 191

20 UNDERTAKER: J. Walsh

ADDRESS: 5800 Arsenal

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Registration District No. ..... File No. .....

Township ..... Registered No. .....

or

Village ..... Primary Registration District No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in hospital or institutio give its NAME inste of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased fro
....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....
and that death occurred, on the date stated above, at ..... n
The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... d

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... d

(Signed) ..... M. D

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, sta (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicida

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191....

20 UNDERTAKER

ADDRESS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan