

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

REC'D JUL 12 1939

20619  
Do not use this space.

**1. PLACE OF DEATH**

(a) County..... 2 Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) or City St. Louis Mo. (d) Street No. 1485 Laurel St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**791  
1008**

Registered No. **5463**

**2. PRINT FULL NAME** Hannie Thal

(a) Residence, No. 1485 Laurel St. L (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Thal.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1, 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
56 57 01 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. at home  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

FATHER 13. NAME David Michaelson 6

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 9

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Walter Thal  
 (ADDRESS) 6435 San Bonita

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE B. Nai Amoona DATE 6/20/39

19. FUNERAL DIRECTOR (NAME) Wagner  
 (ADDRESS) 4356 Lindell Blvd

20. FILE JUN 19 1939 J. B. ...

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-18, 1939

22. I HEREBY CERTIFY, That I attended deceased from 2.5, 1939, to 6.18, 1939

I last saw him alive on 6.18, 1939. Death is said to have occurred on the date stated above, at 9:30 p. m.  
 The principal cause of death and related causes of importance were as follows:

Central hemorrhage  
Concussion of brain (Rt.)  
(Post-operative)

Name of operation Radical Excision of brain Date of 5.25.39  
 What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify  
 (Signed) Wagner M. D.  
 (Address) 4356 Lindell Blvd

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

WHILE SERVING WITH OUR ARMY THIS IS A PERMANENT RECORD I X18605

**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.....

*J. G. Sullivan*

Licensed Embalmer No. *1122*

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, above space should be left blank.**