

OCT 20 1940

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

Do not use this space.

32969

1. PLACE OF DEATH

County St Charles 20 Registration District No. 755
Township Ferne Osage Primary Registration District No. 5796a
City Ferne Osage (No. _____) St. _____ (Ward)

File No. _____
Registered No. _____

2. FULL NAME

Herry Thielking
(a) Residence, No. Ferne Osage Mo. nu
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Louise Thielking</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 27 - 1862</u>		
7. AGE	YEARS <u>77</u>	MONTHS <u>9</u>
	DAYS <u>10</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6th 1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1939, to Oct 6th 1940

I last saw him alive on Oct 1st 1940. Death is said to have occurred on the date stated above, at 12:30 P. m.

The principal cause of death and related causes of importance were as follows:
Chronic valvular heart disease Date of onset 1935

Other contributory causes of importance:
Old age, hard farm labor

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Augusta S</u>
	13. NAME <u>Frederick Thielking b</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany S</u>
	15. MAIDEN NAME <u>M. Willigman</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St Charles Mo</u>
	17. INFORMANT (ADDRESS) <u>Olis Thielking Augusta Mo</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ferne Osage cemetery</u> DATE <u>Oct 9</u> 19 <u>40</u>
	19. UNDERTAKER (ADDRESS) <u>Thielking funeral home Augusta Mo</u>
	20. FILED <u>10/8</u> 19 <u>40</u> <u>John H. Brandt</u> Registrar

Name of operation None Date of _____

What test confirmed diagnosis? Physician Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? None Date of injury None 19____
Where did injury occur? None occurred (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify No
(Signed) Benjamin Brandt, M. D.
(Address) 677

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.



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32969

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 755

Primary Registration District No. 5996a

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Fanning Cause
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community years, months or days (Specify whether)

3. (a) PRINT FULL NAME Henry J. Thielking

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex m Color or race W
5. Color or race

6. (b) Name of husband or wife
6. (a) Single, widowed, married, divorced wid
6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 10
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct 8 1940 (b) Galore Clayton (Registrar's signature) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH Month Oct day 6 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

Signature Benj Brandt (M. D. or other)

Address Date signed

SUPPLEMENTAL COPY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

