

V. S. No. 2
FORM—8-43
rev. 5-17-39
I X37823

32440

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9389**

FILED NOV 10 1945

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

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

3. (a) PRINT FULL NAME Anna Thielecke
3. (b) If veteran, name war. None 3. (c) Social Security No. None

4. Sex Female 5. Color, or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Walter G. Thielecke 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 15, 1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business None

12. Name Martin Schoepf

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Mienziinger

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Walter L. Thielecke
(b) Address 601 Dover Place

17. (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 S. Grand Blvd.

19. (a) OCT 30 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 117
(If outside city or town limits, write "RURAL")
(d) Street No. 601 Dover Place 9
(If rural, give location)
(e) Citizen of foreign country? Yes. (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 28th
year 1945 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from Oct 1 1945 to Oct. 28 1945
that I last saw her ER alive on Oct. 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus 2 Hrs
Due to Post Operative & Deep X-Ray Therapy
Due to _____

Other conditions Carcinoma of Breast 6 mos?
(Include pregnancy within 3 months of death)

Major findings: Carcinoma Rt breast
Of operations _____
Of autopsy _____

Duration
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 Arnold S. Klein (M. D. or other) M.D.
Address 2632 E. Kingshighway Date signed 10/29/45

1975. 10

1975. 10
L.A. 1475

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 Alfred G. Bodeker
Licensed Embalmer No. 2663
P. O. Address 5934 Alpha

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.