

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **22264**
Registrar's No. **5175**

Registration District No. **318**
Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **DePaul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Kirkwood 22**
(If outside city or town limits, write "RURAL")
(d) Street No. **439 N. Geyer Rd**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Albert A. Theiling**

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. **492-07-2625**

20. DATE OF DEATH: Month **June** day **8**
year **1946** hour **8** minute **10 P.** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Loyola A. Theiling**
6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **March 25 1895**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **6-2-46**
to **6/8**
that I last saw him alive on **6/8**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
51 2 13 hr. min.

Immediate cause of death
Intra-cranial Hemorrhage 10 days
Due to **(Possible aneurysm)**
Due to **No Aneurysm**

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

Other conditions (Include pregnancy within 3 months of death)
J. J.

10. Usual occupation **Mill-work Treasurer**

11. Industry or business **Theiling-Lothman Man. Co**

Major findings: Of operations _____
Of autopsy **Obtained - data in patient's hands Dr. Seiber**

12. Name **Charles Theiling**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Loyola A. Theiling**

(b) Address **439 N. Geyer Rd Kirkwood Mo**

17. (a) **Burial** (b) Date thereof **6/11/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Meyer-Pfzinger Fun.**
(b) Address **Kirkwood 22 Mo**

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? _____

19. (a) **JUN 10 1946** (b) **J. J. Bradest**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury **6/10/46**
23. Signature **Edmund J. Seiber** (M. D. or other)
Address **13509** Date signed _____

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

MOTHER FATHER

JUN 10 1946

MAY 21 1947

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 *John M. Meyer*
Licensed Embalmer No. *3488*
P. O. Address *331 S. Kirkwood*
Kirkwood 22 Mo

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.