

FILED AUG 7 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **266**

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **Fulton, Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**State Hospital No 1 Fulton, Mo**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **14 yrs, 2 mo, 3 days**  
(Specify whether)

In this community  
years, months or days

3. (a) PRINT FULL NAME **FRANK THEILMAN**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: ? (Month) ? (Day) 1873 (Year)

8. AGE: Years 74 Months ? Days ? If less than one day hr. min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) U.S.A. / (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **State Hospital Record**

(b) Address **Fulton, Mo**

17. (a) **Burial** (b) Date thereof **7-30-47** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **State Hosp Cemetery**

18. (a) Signature of funeral director **G.P. Hall**

(b) Address **State Hosp #1 Fulton, Mo**

19. (a) **7-30-1947** (b) **Joseph N. ...** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Charles**  
(c) City or town **Augusta, Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Unknown**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26** 15  
year **1947** 6 hour 0 minute A.M.

21. I hereby certify that I attended the deceased from **24 July** 1947, to **26 July** 1947;  
that I last saw him alive on **25 July** 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Lobar Pneumonia** Duration **2 days**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: **Gen. arterio Sclerosis**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **108**

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 **G.S. Waraick** (M. D. or other) **0**  
Address **Fulton, Mo** Date signed **26 July 1947**

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

4  
1  
2

**RECEIVED**  
District Health Officer No. 9,  
District File Number  
Date Filed 8-6-47

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**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.....

Licensed Embalmer No.....

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, fact should be so stated above.-**