No. 2
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-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 8 1947
#95509

Registration District No. 318

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 100

State File No. 26587

Registrar's No. 3230

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

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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

1828 Hickory St.,
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME THOMAS A. THYGESON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 6th, ? 1867
(Month) (Day) (Year)

8. AGE: Years abt-80 | Months | Days | If less than one day hr. min.

9. Birthplace Norway 4
(City, town, or county) (State or foreign country)

10. Usual occupation OAA

11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital.

17. (a) Anatomical Board (b) Date thereof 8-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter
(b) Address AUG 29 1947 3500 Rutgers

19. (a) (b) J. F. Bridder
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6th
year 1947 hour 6:00 minute A M.

21. I hereby certify that I attended the deceased from 7/18/47
, 19, to Aug. 6th 1947
that I last saw him alive on Aug. 6th 1947
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia, labor | ? |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature K. D. Gregory 1515 Lafayette 8/6/47 (Date of other)

Address Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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 Howard F. Rowland

Licensed Embalmer No. 3114

P. O. Address Olive Miss

**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.**