

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11174

State File No.

318

REG. DIST. NO. 1003 PRIMARY REG. DIST. NO. 2408 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2408	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital				d. STREET ADDRESS (If rural, give location) 3508 N. 22nd. St			
3. NAME OF DECEASED (Type or Print) a. (First) Frank		b. (Middle) _____		c. (Last) Thiel		4. DATE OF DEATH (Month) (Day) (Year) 3 12 1950	
5. SEX male <input checked="" type="radio"/>		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 16-1879	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Hungary 8	
12. CITIZEN OF WHAT COUNTRY? _____				13a. FATHER'S NAME Lawrence Thiel		13b. MOTHER'S MAIDEN NAME Anna Blow.	
14. NAME OF HUSBAND OR WIFE Mary Thiel				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME Mary Thiel				ADDRESS 3508 N. 22nd. St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3-8-50	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		II. OTHER SIGNIFICANT CONDITIONS none					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) 381X (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 3-8-50, 19__, to 3-12-50, 19__, that I last saw the deceased alive on 3-12-50, 19__, and that death occurred at 6:10 P.M., from the causes and on the date stated above.							
23a. SIGNATURE Walter J. Leidner		(Degree or title) _____		23b. ADDRESS 1506 St. Louis		23c. DATE SIGNED 3-13-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-10-1950		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Missouri	
DATE REC'D BY LOCAL REG. MAR 13 1950		REGISTRAR'S SIGNATURE J. B. Kasper		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner U. 2223 St. Louis Ave.			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Spacemann, 506 St. Louis

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *John P. Buchholz*
Licensed Embalmer No. *1674*

P. O. Address *2223 St. Louis*

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.