

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32218**

FILED OCT 5 1951

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 3291	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St. Louis			
b. CITY OR TOWN Manchester		c. LENGTH OF STAY (in this place) 34 yrs		c. CITY OR TOWN Richmond Heights		4490	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Home # 2				d. STREET ADDRESS (If rural, give location) 7439 Warner			
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT		b. (Middle) B.		c. (Last) THIEMAN		4. DATE OF DEATH (Month) (Day) (Year) 9-29-1951	
5. SEX male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug 19-1886	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chicago Illinois	
12. CITIZEN OF WHAT COUNTRY? USA				13a. FATHER'S NAME unk.		13b. MOTHER'S MAIDEN NAME unk.	
14. NAME OF HUSBAND OR WIFE Alma. Deceased				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. 487-12-2959	
17. INFORMANT'S SIGNATURE OR NAME Sara Seidler				ADDRESS 4132 Sherwood			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis					
		DUE TO (c) 4222					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
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) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 July 12, 1948 to Sept 29, 1951 , that I last saw the deceased alive on Sept 26, 1951 , and that death occurred at 7:52 a. m. , from the causes and on the date stated above.							
23a. SIGNATURE R. P. Jensen				(Degree or title) M. D.		23b. ADDRESS Manchester Mo.	
23c. DATE SIGNED 9/29/51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-1-51		24c. NAME OF CEMETERY OR CREMATORY St Matthews	
24d. LOCATION (City, town, or county) (State) St Louis Mo.		DATE REC'D BY LOCAL REG. 10-1-51		REGISTRAR'S SIGNATURE Robert P. Jensen, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	
						ADDRESS Manchester Ave.	

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

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.....

Signed.....
Student Embalmer

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.