

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 2 - 1954

State File No. **21340**  
Registrar's No. **5747**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN <b>St. Louis</b>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4491 West Pine Blvd</b>			e. STREET ADDRESS (If rural, give location) <b>19 4491 West Pine Blvd. 21990</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Clara</b>		b. (Middle) <b>B</b>	c. (Last) <b>Thiel</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 25 1954</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Nov 21 1866</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Kobusch</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mr. Jack Thiel, 3911 Brooklyn, Kansas City, Mo.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.	<p align="center"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Atherosclerosis Cordis Vasculae 5 yrs.</b> <i>Disease</i></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Ch. Cholecystitis &amp; Cholelithiasis 4 yrs.</b></p>				
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? <b>4221</b>			
22. I hereby certify that I attended the deceased from <b>Nov. 18, 1949</b> , to <b>June 25, 1954</b> , that I last saw the deceased <b>dead</b> on <b>June 25, 1954</b> , and that death occurred at <b>3:30 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Charles W. Madison M.D.</b>		23b. ADDRESS <b>4020 W. Florissant</b>		23c. DATE SIGNED <b>6/26/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>June 28, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>JUN 28 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b>		

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clement M. Gray*.....

Licensed Embalmer No. *3732*

P. O. Address *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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.