

FILED FEB 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3177

318

1003

State File No. ....

0307

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
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 town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>3 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		2019		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>6920 Michigan ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Martin</b>		b. (Middle) <b>F.</b>		c. (Last) <b>Thielker</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 11, 1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>		8. DATE OF BIRTH <b>Feb. 2, 1892</b>	9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wabash R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <b>Frederick Thielker</b>			13b. MOTHER'S MAIDEN NAME <b>Caroline Wecke</b>			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Edw. Hesemann</b>		ADDRESS <b>6646 Idaho ave.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchio pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <b>Arteriosclerotic</b>				
				DUE TO (c) <b>Heart Disease &amp; Failure</b>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4200				
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) _____		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 <b>March 1957</b> , to <b>Jan 11, 1955</b> , that I last saw the deceased alive on <b>Jan 11, 1955</b> and that death occurred at <b>3.30 p.m.</b> from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Joseph P. Conroy MD</b>				23b. ADDRESS <b>906 Olive</b>		23c. DATE SIGNED <b>1-12-55</b>		
24a. BURIAL CREMATION, REMOVAL (Specify) _____		24b. DATE <b>Jan. 15, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>2000 Lemay Ferry Road Lemay, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>JAN 12 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister U. &amp; L. Co. 7814 S. Broadway</b>				

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.....  
Student Embalmer

Signed *Lenius C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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.