

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **29061**BIRTH NO. 55158-55 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1006

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>7 days</b>		e. STREET ADDRESS (If rural, give location) <b>3025 1/2 Penn Street</b> <b>01170</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			
3. NAME OF DECEASED (Type or Print) <b>JEANNE</b>	a. (First)	b. (Middle) <b>CLAIRE</b>	c. (Last) <b>THIEL</b>
4. DATE OF DEATH <b>September 16, 1955</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	
8. DATE OF BIRTH <b>Sept. 8, 1955</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Days <b>7</b> IF UNDER 2 HRS. Hours <b>17</b> Min. <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>St. Joseph, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Robert Ernest Thiel</b>		13b. MOTHER'S MAIDEN NAME <b>Joan Marie Maiers</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>R. E. Thiel, 3025 1/2 Penn St., St. Joseph, Mo.</b>		ADDRESS	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Intracranial Hemorrhage</b>  ANTECEDENT CAUSES <b>Due to (b) Prematurity</b>  <b>Due to (c) 7605</b>  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <b>Sept 8, 1955</b> , to <b>Sept 16, 1955</b> , that I last saw the deceased alive on <b>Sept 16, 1955</b> , and that death occurred at <b>4:40A m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>H. E. Wachtel M.D.</b>		23b. ADDRESS <b>Kirkpatrick Bldg., City</b>	
23c. DATE SIGNED <b>9-17-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Sept 16, 1955</b>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>Lagrange, Illinois</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Sept 21, 1955</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Katherine M. Allison</b> <b>Herman M. Sidenfader</b> <b>St. Joseph, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

Student.....  
Signature of Student Embalmer

Signed *Herman W. Sidenfaden*.....

Licensed Embalmer No. *2738*.....

P. O. Address *St. Joseph Me*.....

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.