#
S. No. 300
v. 10.48

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FILED JUN 20 1956

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 22156

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5559

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

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis State Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 5100 Arsenal Street

13 2129

**3. NAME OF DECEASED** (Type or Print)
a. (First): Margaret
b. (Middle):
c. (Last): Thier

**4. DATE OF DEATH** (Month) June (Day) 10 (Year) 1956

**5. SEX**: Female 1

**6. COLOR OR RACE**: White

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Single D

**8. DATE OF BIRTH**: May 16, 1892

**9. AGE** (In years last birthday): 64 | 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): Domestic

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (City and State or Foreign Country): Germany 4

**12. CITIZEN OF WHAT COUNTRY?**: USA.

**13a. FATHER'S NAME**: Christian Thier

**13b. MOTHER'S MAIDEN NAME**: Margaret Schoemaker

**14. NAME OF HUSBAND OR WIFE**:

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown):
(If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT'S SIGNATURE OR NAME**: ELIZABETH VORWITH
**ADDRESS**: 3120 UTAH

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Uterine tumor — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.* Paranoid Schizophrenia — 45 yrs

**19a. DATE OF OPERATION**: June 6, 1956
**19b. MAJOR FINDINGS OF OPERATION**: Intestinal obstruction
**20. AUTOPSY?** YES ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Oct. 24, *19* 10, *to* June 10, *19* 56, *that I last saw the deceased alive on* June 10, 1956, *and that death occurred at* 2:05 a *m., from the causes and on the date stated above.*

**23a. SIGNATURE**: Samuel R Joseph M.D. (Degree or title)
**23b. ADDRESS**: 5100 Arsenal Street
**23c. DATE SIGNED**: 6/10/56

**24a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**24b. DATE**: JUNE 12 1956
**24c. NAME OF CEMETERY OR CREMATORY**: NEW ST. MARCUS
**24d. LOCATION** (City, town, or county): ST. LOUIS (State): Mo

**DATE REC'D BY LOCAL REG.**: JUN 11 1956
**REGISTRAR'S SIGNATURE**: J. Earl Smith M.D.
**25. FUNERAL DIRECTOR'S SIGNATURE**: Thomas Kutis M.D.
**ADDRESS**: 2906 Prairie
(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalm

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student..... Signature of Student Embalmer

Signed. Homer C Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Ga

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.