

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29218**

FILED SEP 6 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7602**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 5 weeks	
d. FULL NAME OF HOSPITAL OR INSTITUTION New Faith Hospital		d. STREET ADDRESS (If rural, give location) 6108 Gambelton Place	

3. NAME OF DECEASED (Type or Print) a. (First) Bernhardt b. (Middle) B c. (Last) Thimmig			4. DATE OF DEATH (Month) (Day) (Year) August 15, 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 18 1888	9. AGE (In years last birthday) 68	# UNDER 1 YEAR # UNDER 1 MONTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Clerk		10b. KIND OF BUSINESS OR INDUSTRY Wagner Electric Co		11. BIRTHPLACE (City and State or Foreign Country) Du Quoin, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Charles Thimmig		13b. MOTHER'S MAIDEN NAME Catherine Kassebaum		14. NAME OF HUSBAND OR WIFE Flora Thimmig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Flora Thimmig, ADDRESS 6108 Gambelton Place	

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) Fractured Skull Subdural Hematoma Cerebral Trauma DUE TO (b) Subdural Hematoma DUE TO (c) Cerebral Trauma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. suffered in fall at Faith Hospital			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Hospital, July 31, 1956			20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT OR SUICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Shop		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo.		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 31 56 ?		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 000 E904.7	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at POA m., from the causes and on the date stated above.					

23a. SIGNATURE (Type or Print) James M. Kelly			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 8.16.56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug 17 1956	24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

DATE REC'D BY LOCAL REG. AUG 16 1956		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc., ADDRESS 2161 E. Fair Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

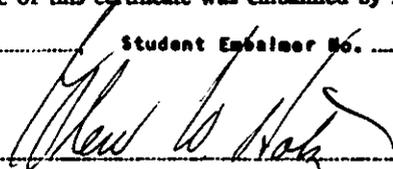
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 3737

P. O. Address St. Louis, Missouri

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.