

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020223
STATE FILE NUMBER

FILED MAY 23 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5059

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN Hosp. 0</u>		d. STREET ADDRESS (If outside, give location) <u>2815 ARSENAL</u>	
3. NAME OF DECEASED (Type or print) First <u>JULIUS</u> Middle <u>M.</u> Last <u>TIEDE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 11 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEER BOTTLER CARLING BREWERY</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
13a. FATHER'S NAME <u>JULIUS TIEDE</u>		14. NAME OF HUSBAND OR WIFE <u>CLARA TIEDE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>CLARA JOKERST 6328 BRADLEY</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) _____ DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Insanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>10-28-57</u> to <u>5-11-58</u> and last saw ^{him} alive on <u>5-11-58</u> Death occurred at <u>7:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Albert J. Gnade M.D.</u>	
22b. ADDRESS <u>3606 Grannis</u>		22c. DATE SIGNED <u>5-12-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL MAY 16 1958</u>		23b. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	
23c. DATE <u>MAY 16 1958</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., Mo</u>	
24. FUNERAL DIRECTOR <u>Thomas Lutes 2906 Grannis</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 13 '58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		26. REGISTRAR'S SIGNATURE <u>G.P.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DR 2-7380
1-4 Nov.

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 *Samuel White*

Licensed Embalmer No. *4347*
P. O. Address *2906*

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.