

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027501

STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6923

300
1-57
2609
3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3800 Shenandoah Ave

3. NAME OF DECEASED (Type or print) First MATTIE Middle M. Last THIAS			4. DATE OF DEATH Month July Day 10 Year 1958		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 15, 1880	9. AGE (In years last birthday) 77	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	-----------------------------------	---------------------------------------	-----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-International Shoe Co.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Washington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Frederick Thias	13b. MOTHER'S MAIDEN NAME Charlotte Gott	14. NAME OF HUSBAND OR WIFE -----
---------------------------------------	---	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None	16. SOCIAL SECURITY NO.	17. INFORMANT William H. Thias	Address 3946 Dover Pl.
---	-------------------------	-----------------------------------	---------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic		INTERVAL BETWEEN ONSET AND DEATH 1 yr 1
DUE TO (b) chronic Nephritis		
DUE TO (c) 592x		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension, edema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 Month, Day, Year 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,actory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--

21. I attended the deceased from Death occurred at 7:00 P. on June 19, 1958 to July 11, 1958 and last saw her alive on July 1, 1958 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Walter E. Cabell M.D.	(Degree or title)	22b. ADDRESS 2253 So 39th	22c. DATE SIGNED 7-11-58
---	-------------------	------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 14, 1958	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
--	----------------------------	---	--

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 1 1958	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.
---	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Richard W. Stevenson*

Licensed Embalmer No. *1007*

P. O. Address

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.