

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028735

STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 115-116 Primary Registration District No. 3030 Registrar's No. 231

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Washington</u> 0362 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>E. Main</u> | | Length of stay in lb. <u>10 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>E. Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Augusta Sophie Theobald</u> | | | 4. DATE OF DEATH Month Day Year <u>Sept. 2, 1958</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 21, 1877</u> |
| 9a. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Month Days Hours Min. <u>4 11</u> | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life. (Men if retired)) <u>Home Maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>William Mueller</u> | 13b. MOTHER'S MAIDEN NAME <u>Sophie Cascke</u> |
| 14. NAME OF HUSBAND OR WIFE <u>Peter Theobald</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, date unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. Irma Halfter, 1324 W. St. Charles Rd., St. Louis, Mo.</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>Coronary thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerotic C-U-R disease</u> | | | <u>? years</u> |
| DUE TO (c) <u>Old age</u> | | | <u>4201</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>13 Aug 1949</u> to <u>2 Sep 58</u> and last saw her alive on <u>2 Sep 58</u> Death occurred at <u>11:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>R. B. Boggs, MD</u> | | 22b. ADDRESS <u>Washington Mo.</u> | 22c. DATE SIGNED <u>3 Sep 58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Sept. 5, 1958</u> | <u>Concordia Cemetery</u> | <u>St. Louis, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Nieburg & Witt, Inc., Washington Mo.</u> <u>L. H. Witt</u> | | 25. DATE RECD. BY LOCAL REG. <u>9/3/58</u> | 26. REGISTRAR'S SIGNATURE <u>F. J. Hedmann</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, & Welfare Public Service

300
1-57

All diseases in Part I must be causally related.

OCT 3 1933

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 *Lester A. Vitt*

Licensed Embalmer No. *3254*
P. O. Address *Washington, D.C.*

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.