

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019944

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1472

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Overland BERKELEY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>BERKELEY Overland 4201</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4205 Marshall Rd.</b> Length of stay in lb <b>9 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>4205 Marshall Rd.</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Veeda</b> Middle <b>Theobald</b> Last <b>Theobald</b>			4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1897</b>
9. AGE (In years last birthday) <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Mill Spring, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John R. Grimes</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Huff</b>
14. NAME OF HUSBAND OR WIFE <b>Charles Theobald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT Address <b>Mr. Charles Theobald, 4205 Marshall</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suicidal gun shot wound of right forehead</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>976X</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Self inflicted gunshot wound of head</b>	
20c. TIME OF INJURY Hour <b>1:45</b> Month <b>5</b> Day <b>27</b> Year <b>59</b> <b>p.m. body found</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>bedroom of home</b>	
20e. CITY, TOWN, OR LOCATION <b>Berkeley</b> COUNTY <b>St. Louis</b> STATE <b>Missouri</b>		20f. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>bedroom of home</b>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>3</b> <i>Raymond H. Harral</i> Coroner		22b. ADDRESS <b>Clayton, Mo.</b>	
22c. DATE SIGNED <b>6/2/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5/29/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral 1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>5-28-59</b>	
26. REGISTRAR'S SIGNATURE <b>John C. Murphy</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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 *Albert R. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

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.