

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021615

FILED VS JUN 9 1960 318 Primary Registration District No. 1003 Registrar's No. 5578 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 3 Weeks		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hosp		d. STREET ADDRESS (If outside, give location) 4606 Tyrolean Ave	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last HARRY S. THIELE	4. DATE OF DEATH Month Day Year 5-27-1960
---	---

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1887	9. AGE (last birthday) 73 Yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
----------------	---------------------------	---	-------------------------------	----------------------------------	---	----------------

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

13a. FATHER'S NAME Henry Thiele	13b. MOTHER'S MAIDEN NAME Ida Ganz	14. NAME OF HUSBAND OR WIFE Marie Thiele
------------------------------------	---------------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-01-9680	17. INFORMANT Marie Thiele	Address 4606 Tyrolean Ave
--	--	-------------------------------	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Ascending Bilateral Kidney infection</i>	<i>3 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Prostatic hyperplasia</i>	<i>Chronic</i>
	DUE TO (c) <i>610x</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic arteriosclerotic heart disease</i>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <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 *May 7, 1960* to *May 27, 1960* and last saw him live on *May 27, 1960*
Death occurred at *7:15 P.M.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Ray C. Dripps M.D.</i>	(Degree or title)	22b. ADDRESS <i>7702 Lundy Ln</i>	22c. DATE SIGNED <i>5/28/60</i>
---	-------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 5-31-1960	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	23d. LOCATION (City, town, or county) 3211 Sublette Ave Mo
--	------------------------	--	---

24. FUNERAL DIRECTOR <i>Biegenhain Bros</i>	ADDRESS 6409 Gravois Av	25. DATE RECD. BY LOCAL REG. MAY 31 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	----------------------------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2118

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Herbert J. Long Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.