

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021617

FILED VS. JUN 8 1960

318

1003

4712

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in lb <u>13 days</u> | | c. CITY OR TOWN <u>St. Woodson Terrace</u> | | 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>St. Louis Chronic Hospital</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>9335 Bataan</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>P.</u> Last <u>Thomann</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1960</u> | | | | | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-10-1883</u> | | 9. AGE (last birthday) <u>77</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker (Retired)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Small Arms Plant</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Cty, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>Adam Thomann</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Caroline Voegel</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Adella</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs. Adella Thomann, 9335 Bataan Drive</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>Basilar Congestion of Lungs</u> DUE TO (b) _____ DUE TO (c) <u>Arteriosclerotic Heart Disease</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 - 13 days.</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>13 days.</u> | | | |
| 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.) <u>4200</u> | | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | Month, Day, Year _____ | | | | | | | | | | | |
| 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 <u>Apr. 20, 1960</u> to <u>May 3, 1960</u> and last saw him alive on <u>May 3, 1960</u> Death occurred at <u>8:10 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u> | | | | | | 22b. ADDRESS <u>5800 Arsenal</u> | | | 22c. DATE SIGNED <u>5/3/60</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>May 6, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann & Son, Inc., 2161 E. Fair Av</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>MAY 4 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Loel Smith, M.D.</u> <u>mjk</u> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Welford B Burnley

Licensed Embalmer No. 4202

P. O. Address St. Louis

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