

FEDERAL BUREAU OF INVESTIGATION  
**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-040549**

FILED VS. **OCT 24 1960**

317

Primary Registration District No.

547

Registrar's No.

3045

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Wellston</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. Mary's Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6446 Spencer Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lena C.</u> Middle <u>Thiele</u> Last			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>18</u> Year <u>1960</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/9/01</u>	<b>9. AGE</b> (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Janitress</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>A and P Co</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Cedarville Ohio</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Harry Carter</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Rose Baker</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Henry W. Thiele</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>2189-20-4108</u>	
<b>17. INFORMANT</b> <u>Henry W. Thiele</u>		Address <u>6446 Spencer Avenue</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>✓✓</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year		PART III. If deceased was female was there a pregnancy in last 90 days.	
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>1954</u> to <u>10/18-60</u> and last saw her alive on <u>10-17-1960</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>James J. Pully M.D.</u>			<b>22b. ADDRESS</b> <u>730 Woodmont Ave.</u>		<b>22c. DATE SIGNED</b> <u>10/20/1960</u>
<b>23. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>Oct 21, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Laurel Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis County, Missouri</u>
<b>24. FUNERAL DIRECTOR</b> <u>Shepard Funeral Home, 1167 Hamilton Avenue</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-20-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>James B. Mumfley M.D.</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

*Lawrence O. Seuling*

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo.

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.