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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                    |  | Length of stay in lb<br>-----   | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Christian Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>4886 Carter Avenue, 15</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|--|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARTIN</b> Middle <b>H.</b> Last <b>THILKING</b>                    |                                  |   | 4. DATE OF DEATH <b>December 25th, 1960</b><br>Month Day Year |  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-5-1892</b>                          | 9. AGE (last birthday)<br><b>68</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cabinet maker</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bensinger Fixture Co.</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Femme Osage, Missouri</b> |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
| 13a. FATHER'S NAME<br><b>William F. Thilking</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Wilhelmina Webbink</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Anna Thilking</b>                        |   |   |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Anna Thilking, 4886 Carter Avenue, 15,</b><br>Address |  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Stapes - Adenoid Syndrome - due to</i><br><i>Complete R-V heart block</i><br><i>arteriosclerotic heart disease</i><br>DUE TO (b) <i>420.0</i><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
|---|---|--|

|                                       |                  |  |  |                              |        |       |
|---------------------------------------|------------------|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY<br>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 July 5, 1960 to 12/26/60 and last saw <sup>her</sup>him alive on 12/26/60  
Death occurred at 3:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                              |   |  |
|--|------------------------------|---|--|
| 22a. SIGNATURE<br><i>Julius Elson M.D.</i> | (Degree or title)            | 22b. ADDRESS<br><i>3720 Westington</i>                                    | 22c. DATE SIGNED<br><i>12/27/60</i>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br><b>12-28-60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Memorial Gardens</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis County, Missouri</b> |

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|---|--|---|
| 24. FUNERAL DIRECTOR<br><b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd.,<br/>FUNERAL HOME, St. Louis, 15, Missouri.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 27 1960</b> | 26. REGISTRAR'S SIGNATURE<br><i>Paul Smith M.D.</i> |
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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 Ralph C. Linder

Licensed Embalmer No. 4275

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.