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BUREAU OF THE CENSUS
JAN 8 1941

STANDARD CERTIFICATE OF DEATH

State File No. 43828

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2388

1. PLACE OF DEATH

(a) County St. Louis

(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 2 mo. 5 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2017a Allen (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Edith Thoele

3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-07-4877

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 11 20 1902
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>38</u>	<u>-</u>	<u>26</u>	hr. - min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper

11. Industry or business _____

12. Name Henry Thoele

13. Birthplace Winnover Germany
(City, town, or county) (State or foreign country)

14. Maiden name Else Wanchover

15. Birthplace St. Falln Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Elsie Thoele

(b) Address 2017a Allen av

17. (a) BURIAL (b) Date thereof DEC 19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schuur

(b) Address 3125 Lafayette St.

19. (a) DEC 17 1940 (b) D. R. Meyer MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16
year 1940 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct 11, 1940, to Dec 16, 1940;
that I last saw her alive on Dec 16, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis 5 mo. (2)

Due to _____

Due to 23

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. E. Largent MD (M. D. or other) _____

Address Robt Koch Hospital Date signed 12/16/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Joseph B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.