

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3096

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **353**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2109	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 10 4136 Farlin avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4136 Farlin ave			

3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) c. (Last) Thuel		4. DATE OF DEATH (Month) (Day) (Year) 1 12 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 2	8. DATE OF BIRTH Nov-19-1879
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 9 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME John W. Keck		13b. MOTHER'S MAIDEN NAME Louisa Emshof		14. NAME OF HUSBAND OR WIFE August H. Thuel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mildred Thuel ADDRESS 4136 Farlin avenue	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary heart failure		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH months	
ANTECEDENT CAUSES		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (b) Atherosclerotic heart disease		DUE TO (c)		years	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4200	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4 1/2 days, to Jan 12, 1950 , that I last saw the deceased alive on Jan 7, 1950 , and that death occurred at 5 1/2 p.m., from the causes and on the date stated above.					

23a. SIGNATURE R. B. Harrison (Degree or title)		23b. ADDRESS 607 N. Grand		23c. DATE SIGNED 1-12-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Jan 14, 1950		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			

DATE REC'D BY LOCAL REG. JAN 12 1950		REGISTRAR'S SIGNATURE R. B. Harrison		25. FUNERAL DIRECTOR'S SIGNATURE A. Know Lull Co. ADDRESS 2507 N. Grand	
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

A.S.U.

EM

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Stanley H. Dixon*

Licensed Embalmer No. *4193*

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