

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26952**
Registrar's No. **6163**

FILED JUL 31 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6163			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis		2129			
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP.				d. STREET ADDRESS (If rural, give location) 5390 PERSHING					
3. NAME OF DECEASED a. (First) ELIZABETH			b. (Middle)		c. (Last) THIELE		4. DATE OF DEATH (Month) (Day) (Year) 6-19-53		
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 8-24-1868			
9. AGE (In years last birthday) 84		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) Missouri			
						12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME SAMUEL IRBINE			13b. MOTHER'S MAIDEN NAME SUSAN M. MEADOR			14. NAME OF HUSBAND OR WIFE MAX			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Ethel Thiele 5390 PERSHING					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis				ANTECEDENT CAUSES					
				DUE TO (b) Fracture of hip					
				DUE TO (c) Senility				OK PET	
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 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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X					
22. I hereby certify that I attended the deceased from June 18, 1953 , to June 19, 1953 , that I last saw the deceased alive on June 18, 1953 , and that death occurred at 1:20 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) A. M. Grand				23b. ADDRESS 3701 Grand		23c. DATE SIGNED 6/20/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-22-53		24c. NAME OF CEMETERY OR CREMATORY VALHALLA		24d. LOCATION (City, town, or county) (State) ST Louis County MO			
DATE REC'D BY LOCAL REG. JUN 20 1953		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS A. Brown & Co 2707 N. Grand					

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *W E Morris*

Signed
Student Embalmer

Licensed Embalmer No. *3360*

P. O. Address *St Louis*

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.