

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29216

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7614**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>58 Yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>5 5859 Etzel</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5859 Etzel</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) c. (Last) <b>Theriac</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>AUG 14 1956</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>D.</b>	8. DATE OF BIRTH <b>Oct. 28, 1881</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder, Small Arms</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					

13a. FATHER'S NAME <b>Leon Theriac</b>		13b. MOTHER'S MAIDEN NAME <b>Theresa Bernard</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Della Theriac</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Sadie Zausch, 5859 Etzel Ave.</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusions</b>		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <b>Arterio sclerosis</b> rise to the above cause (a) stating the underlying cause last.  DUE TO (c)			
		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 <b>420.1</b>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **956 P.M.**, from the causes and on the date stated above.

22a. SIGNATURE <i>Joseph Theriac</i>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>8/15/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 17, 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	
		23d. LOCATION (City, town, or county) (State) <b>Belleville, Ill.</b>			

DATE REC'D BY LOCAL REG. <b>AUG 16 1956</b>		REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Arthur J. ... 384 ...</i>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

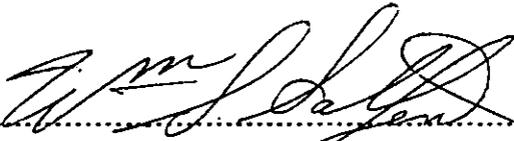
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STATEMENT BY LICENSED EMBALMER

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.....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 469

P. O. Address 3840

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.