

Health, Welfare
Public
Service

300

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STANDARD CERTIFICATE OF DEATH

XC-17 479 912

SL 18910

FEB 24 1959

Registration District No.

Primary Registration District No.

Registrar's No.

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, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in lb 14 days	d. STREET ADDRESS (If outside, give location) 1209 ALLEN
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First FRED Middle THIELMAN Last			Month FEBRUARY Day 7 Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/86
9a. AGE (In years last birthday) 72		9b. UNDER 1 YEAR Months Days	9c. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
13a. FATHER'S NAME THEODORE THIELMAN		13b. MOTHER'S MAIDEN NAME AUGUSTA SCHICKLER	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLUS OF CEREBRAL VESSELS			INTERVAL BETWEEN ONSET AND DEATH 12 DAYS
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE			
DUE TO (c) 420. OF			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) SUB TROCHANTERIC FRACTURE OF RIGHT FEMUR			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Fell at home	
20c. TIME OF INJURY Hour Month, Day, Year a.m. ? p.m. 1-21-1959			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 232 Home	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis, Missouri
21. I attended the deceased from 1/24/59 to 2/7/59 and last saw him alive on 2/7/59 Death occurred at 3:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Zoltan J. Lucas, M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 2/7/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 2/10/59	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	23d. LOCATION (City, town, or county) (State) St Louis Missouri
24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. FEB 10 59	26. REGISTRAR'S SIGNATURE Leart Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

mjl

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed George J. Svoboda Jr......

Licensed Embalmer No. 4899.....

P. O. Address 1926 Albee.....

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.