

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1960

-60-038647

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9225** STATE FILE NUMBER

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>Shrewsbury</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5020 Hi-View</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>J</b> Last <b>THYSON</b>			4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1960</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1888</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Axelson Mfg Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Thyson</b>			13b. MOTHER'S MAIDEN NAME <b>Luisa Lollebach</b>			14. NAME OF HUSBAND OR WIFE <b>-----</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>492-20-0325</b>		17. INFORMANT Address <b>Arleen Brown Fullerton, Calif.</b> <b>Audrey Smith Phoenix, Ariz.</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease 8 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		
		DUE TO (c) <b>420.0</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Myocardial Infarction (old)</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____				

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <b>Nov. 1 1951</b> to <b>9-17-60</b> and last saw <sup>her</sup> him alive on <b>9-16-60</b> Death occurred at <b>9:40 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Doctor or title) <b>William A. Turner M.D.</b>		22b. ADDRESS <b>4401 Hampton</b>		22c. DATE SIGNED <b>9-19-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	23b. DATE <b>9/20/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	

24. FUNERAL DIRECTOR ADDRESS <b>John L Ziegenhein &amp; Sons 7027 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 19 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*C. P. Kedwell*

Licensed Embalmer No. 3877

P. O. Address 7027 Grava

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.