

No. 2
-11-10-39
5-11-39
p 11 X21422

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17389**

JUN 17 1940
Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1916**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Hours**
(Specify whether
In this community **39 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1226 Troost Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **---** years.

3. (a) PRINT FULL NAME **Mr. Albert Oliver F. Teske**
(b) If veteran, **No** name war
(c) Social Security No. **496-01-1567**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **5**
year **1940** hour **7** minute **40 P.M.**

4. Sex **Male** 5. Color or race **White**
6. (b) Name of husband or wife **Mrs. Evelyn D. Teske**
7. Birth date of deceased **August 29 1900**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **19** to **19**
that I last saw him alive on **19**
and that death occurred on the date and hour stated above.

8. AGE: Years **39** Months **8** Days **7**
If less than one day **hr. min.**

Immediate cause of death
Acute Cerebral Edema with Gross Metastases

9. Birthplace **Kansas City Missouri**
(City, town, or county) (State or foreign country)

Due to **Acute encephalitis of non epidemic type**
Other conditions: **None**
(Include pregnancy within 3 months of death)

10. Usual occupation **Baker**
11. Industry or business

MOTHER FATHER
12. Name **Gus F. Teske**
13. Birthplace **Soberkfeld Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Ida B. Lovell**
15. Birthplace **Springfield Illinois**
(City, town, or county) (State or foreign country)

Major findings:
Of operations
Of autopsy **See of m**
Underline the cause to which death should be charged statistically.

16. (a) Informant **Clyde C. Hasten**
(b) Address **7222 So. Benton**
17. (a) **Burial** (b) Date thereof **May 8, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mount Moriah Cemetery**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place; in public place?
(e) While at work (Specify type of place)
(f) Means of injury

18. (a) Signature of funeral director **D. W. Newcomb**
(b) Address **1401 Brush Creek Blvd. May 7, 1940**
19. (a) (Date received local registrar) (b) **M. M. Crowe**
(Registrar's signature)

23. Signature **[Signature]** (M. D. or other)
Address **[Signature]** Date signed **5/7/40**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed: *Emile M. Calhoun*

Licensed Embalmer No. *3506*

P. O. Address *K. C. Mo.*

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, above space should be left blank.