

Registration District No. **DEC 22 1941 791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bethesda Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5330 Pershing Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **31st**
year **1941** hour **9** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Oct 24** 19**41** to **Oct 31** 19**41**
that I last saw him alive on **Oct 31** 19**41**
and that death occurred on the date and hour stated above

Immediate cause of death: **Carcinoma of Colon Duodenum and Pancreas**
Due to **Primary site was Colon**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **Carcinoma of Colon Duodenum and Pancreas**
Of operations _____
Of autopsy _____

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? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **Phel W Stewart** (M. D. or other) _____
Address **1st St Bldg** Date signed _____

3. (a) PRINT FULL NAME **Lotta Tichenor**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 9th 1872**
(Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **22**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cashier**

11. Industry or business **Finnegan Cordage Co.**

12. Name **Ely D. Tichenor**

13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Amanda N. Johnson**
(City, town, or county) (State or foreign country)

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J.C. Henniges**

(b) Address **5330 Pershing Ave.**

17. (a) **Burial** (b) Date thereof **11-3-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director _____

(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **NOV 1 1941** (b) **J. J. Bussick**
(Date received local registrar) (Registrar's signature)

847 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. J.W. Stewart
Lister Bldg. 2-4 P.M.

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

Richard H. Lehmann

Licensed Embalmer No. 3395

P. O. Address.....

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, fact should be so stated above.