

No. 2
-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38154

State File No. _____

FILED DEC 10 1942
Registration District No. _____

Primary Registration District No. 101

Registrar's No. 2341

1. PLACE OF DEATH:

(a) County. St. Louis

(b) City or town. Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 22 days
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo. (b) County. St. Louis

(c) City or town. University City
(If outside city or town limits, write "RURAL")

(d) Street No. 7551 Lynn Ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ethel Teare

3. (b) If veteran, name war ?

3. (c) Social Security No. ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7
year 1942 hour 2 minute 50 P. M.

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Archie Teare

6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased June 22 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-16-42
_____ 19, to 11-7-42, 19 _____;
that I last saw her alive on 11-7-42, 19 _____;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>4</u>	<u>16</u>	hr. _____ min.

Immediate cause of death Respiratory Failure Duration 2du

Due to Central Hemorrhage 3utro

Due to _____

9. Birthplace Grant County Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name George Elise

13. Birthplace unknown England
(City, town, or county) (State or foreign country)

14. Maiden name Della Gray

15. Birthplace Winneconne Wis.
(City, town, or county) (State or foreign country)

16. (a) Informant Archie J Teare

(b) Address 7551 Lynn

17. (a) Removal (b) Date thereof 11-9-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial St. Patrick

18. (a) Signature of funeral director Alward

(b) Address 2175 D

19. (a) NOV 9 - 1942 (b) E J Mc Laran
(Date received local registrar) (Registrar's signature)

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?

While at work? _____ (Specify type of place) (d) Means of injury _____

23. Signature John G. Matthew (M. D. or other) _____
Address St. Louis Co Hosp Date signed 11/9/42

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

96
302

96
302

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 *James E. McCullough*.....

Licensed Embalmer No. *2460*.....

P. O. Address *6175 Delmore*.....

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.