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

40806

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS.

FILED JAN 11 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 943

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community ~~Residence~~ ~~Mt Vernon Mo~~ ~~all his life~~ ~~[illegible]~~

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence 55

(c) City or town Mt Vernon, Mo (Rural) 00
(If outside city or town limits, write "RURAL")

(d) Street No. X
(If rural, give location)

(e) Citizen of foreign country? X (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME John Christian Tettenhorst

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

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

6. (b) Name of husband or wife Mrs Rilla Tettenhorst 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased July (Month) 6 (Day) 1889 (Year)

8. AGE: Years 53 Months 5 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace Mt Vernon - ~~Mo (Rural)~~ Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Agriculture & Dairying

FATHER
12. Name Albert Tettenhorst
13. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Sarah Frederking
15. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs Rilla Tettenhorst
(b) Address Mt Vernon Mo (Rural)

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 30 1942 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Mt Vernon Mo. Iso Cem

18. (a) Signature of funeral director George B Orr
(b) Address Mt Vernon Mo

19. (a) 12-30-42 (Date received local registrar) (b) D W Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30th year 1942 hour 2 minute P M.

21. I hereby certify that I attended the deceased from Dec 26, 1942, to Dec 30, 1942; that I last saw him alive on Dec 30, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary abscess	3 wk
Due to	
Due to	
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.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Guy D Callaway (M. D. or other) MD

Address Springfield Mo Date signed 1/1/43

987

(Licensed Embalmer's Statement on Reverse Side)

JAN 19 1943

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 George D. Orr

Licensed Embalmer No. 946

P. O. Address Mt. Vernon, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40806

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 943

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Spangfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bapt Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hr (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lawrence
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John C. Tettenhorst
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Rosa
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased July 6 — 1888 (Month) (Day) (Year)
8. AGE: Years 53 Months 5 Days 7 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name Albert Tettenhorst
13. Birthplace Ill (City, town, or county) (State or foreign country)
14. Maiden name Sarah Frederickson
15. Birthplace Ill (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary abscess	3 wks
Due to (Acute phlegmonic non-malignant non tuberculous)	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 14d	
Of autopsy	

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

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY