V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19283

FILED JUL 14 1945 818

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 5475

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Isolation Hospital
5600 Arsenal St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12/4/44--6/22/45 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CHARLES TILLISON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Mary Tillison

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

7. Birth date of deceased 3 (Month) 5 (Day) 1883 (Year)

8. AGE:

Years	Months	Days	If less than one day
62	3	17	hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation ? Nil

11. Industry or business

FATHER
12. Name John Tillison
13. Birthplace ? (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Sarah Dowling
15. Birthplace ? (City, town, or county) 9 (State or foreign country)

16. (a) Informant A. Hahesy,
(b) Address 5600 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation Troy, Ill.

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) JUN 23 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 22
year 45 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from 12/4/44, 19, to 6/22/45, 19;
that I last saw him alive on 6/22/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Addisons disease Non-tubercular

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

65

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 0

23. Signature R W Maxwell (M. D. or other)

Address 5600 Arsenal St. Date signed 6/22/45

(Licensed Embalmer's Statement on Reverse Side)

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 Flonny Eynck

Licensed Embalmer No. 1284

P. O. Address St Louis 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, fact should be so stated above.