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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35920

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9652

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 2707 St. Louis Ave. /

(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 Missouri (b) County 000

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

(d) Street No. 2707 St. Louis, Ave. 2017 9

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alois C. Tenbarge

3. (b) If veteran, name war

3. (c) Social Security No. 493-09-8869

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Frances Tenbarge

6. (c) Age of husband or wife if alive 1884 years

7. Birth date of deceased March (Month) 6 (Day) 1884 (Year)

8. AGE: Years 61 Months 8 Days 0 If less than one day hr. min.

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

10. Usual occupation Guard

11. Industry or business Combustion Eng. Co.

FATHER
12. Name John Tenbarge
13. Birthplace Indiana (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Wolf
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Tenbarge

(b) Address 2707 St. Louis, Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 10 (Day) 1945 (Year)

(c) Place: burial or cremation Haubstadt, Ind.

18. (a) Signature of funeral director Sullivan Funeral Dir.

(b) Address 2849 No. Euclid Ave.

19. (a) NOV 7 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th. year 1945 hour 10 minute 00 A M.

21. I hereby certify that I attended the deceased from April 17-1945, 19 to Nov-6-, 1945 that I last saw him alive on Nov-5-, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to

Due to Hypertension Cerebral Hemorrhage L side

Other conditions (Include pregnancy within 3 months of death) Heme Plegia

Major findings: Of operations none

Of autopsy no

Duration

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) no

(b) Date of occurrence

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? (e) Means of injury none

23. Signature [illegible] (M. D. or other)

Address 2739 N Grand St Louis Date signed 11-6-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Harmann

2739 No. Grand 3.00 P.M.

DEC 19 1945

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.....

Licensed Embalmer No. 3553

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.