S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 14 1948

Registration District No. 377

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6676

State File No. 11138

Registrar's No. 893

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

1. PLACE OF DEATH:
(a) County Saint Louis
(b) City or town Koch - Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 126 days (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saint Louis
(c) City or town Saint Louis 000
(If outside city or town limits, write "RURAL")
(d) Street No. 3913 a Cote Brilliante 17
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 9
If yes, name country 1

3. (a) PRINT FULL NAME HELEN R. TENNYSON

3. (b) If veteran, name war

3. (c) Social Security No. 498-16-9461

4. Sex f 1

5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Homer Tennyson

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased 10 (Month) 27 (Day) 1916 (Year)

8. AGE: Years 31 Months 5 Days 8 If less than one day hr. min.

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

10. Usual occupation factory

11. Industry or business

FATHER
12. Name Walter Ballance
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Grace Overlease
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Hospital record
(b) Address Robert Koch Hospital - Koch, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-48 (Month) (Day) (Year)
(c) Place: burial or cremation Rolla

18. (a) Signature of funeral director Rowland Mortuary Inc
(b) Address 4104 Manchester

19. (a) 4-8-48 (Date received local registrar) (b) Cecil A. J. Sharp MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
year 1948 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 9, 1946 to April 5, 1948
that I last saw her alive on April 5, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	2 1/2 years
Due to	
13 b	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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 John T. Uglish M.D. (M.D. or other)
Address Robert Koch Hospital Date signed 4-5-48

Jefferson City Printing Co.

(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 Howard F. Rowland

Licensed Embalmer No. 5114

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.