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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

21392

FILED JUN 28 1948

State File No. _____

5414

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(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 _____

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

(d) Street No. 3710 Olive St.
Memorial (If rural, give location)

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

3. (a) PRINT FULL NAME Roena C. Teters

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th
year 1948 hour 7 minute 35 A. M.

21. I hereby certify that I attended the deceased from 4/28/48
19____ to June 14th, 1948
that I last saw him ET alive on June 14th, 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Omar Teters

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased December 25 1872
(Month) (Day) (Year)

Immediate cause of death Encephalomalacia Duration

Due to Arteriosclerosis

Due to _____

8. AGE: Years 75 Months 5 Days 19
If less than one day hr. _____ min. _____

Other conditions Psychosis with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Arteriosclerosis
Of operations: Coronary heart disease
Senile arteriosclerosis
Of autopsy: Encephalomalacia

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

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George W. Crum

13. Birthplace Shelby Co. Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Kate Evans

15. Birthplace Shelby Co. Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Omar Teters

(b) Address 3710 Olive St.

17. (a) Burial (b) Date thereof 6-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) JUN 14 1948 (b) J. F. Bredeck
(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) (e) Means of injury _____

23. Signature Accidentally killed by M.D.
1515 Lafayette (M. D. or other) _____

Address _____

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

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 *John D. Hennick*.....

Licensed Embalmer No. *4194*.....

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.