

FILED FEB 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3785

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>381</u>		PRIMARY REG. DIST. NO. <u>4511</u>		Registrar's No. <u>10</u>	
1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>		c. LENGTH OF STAY (in this place) <u>844's</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>		d. STREET ADDRESS (If rural, give location) <u>135</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>—</u>				d. STREET ADDRESS (If rural, give location) <u>—</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arci</u>			b. (Middle) <u>Ellen</u>			c. (Last) <u>Tenteborg</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>2 5 1949</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>4-20 1864</u>		9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Harold Kelly</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Aylor</u>		14. NAME OF HUSBAND OR WIFE <u>Jno. H. Tenteborg - dead</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rosa Brown</u>		ADDRESS <u>Milan, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>SENILITY WITHOUT DEMENTIA</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>CHRONIC HYPERTROPHIC ARTHRITIS.</u> DUE TO (c) <u>7730</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>GENERAL ARTERIOSCLEROSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>19 yrs.?</u> <u>10 yrs.?</u> <u>25 yrs.?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>NO OPERATION</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-7</u> , 1948; to <u>2-4</u> , 1949, that I last saw the deceased alive on <u>2-4</u> , 1949, and that death occurred at <u>2 1/2</u> p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph E. Prior, D.O.</u>				23b. ADDRESS <u>MILAN, MISSOURI.</u>		23c. DATE SIGNED <u>2-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/7/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Graveling</u>		24d. LOCATION (City, town, or county) (State) <u>Milan - Sullivan Mo</u>	
DATE RECD BY LOCAL REG. <u>Feb. 10 - 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dwight Samsone</u>		ADDRESS	

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

RECEIVED

District Health Officer No.

District File Number 2-493

Date Filed FEB 14 1949

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 _____

D. Norris Cleeton

Student Embalmer No. 238

working under my personal supervision.

Signed D. Norris Cleeton
Student Embalmer

Signed Dwight Schaefer

Licensed Embalmer No. 2667

P. O. Address Urban - 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.