

FILED JUL 30 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 24892

6407

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>				b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		17				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6020 WATERMAN</u>				d. STREET ADDRESS (If rural, give location) <u>5 6020 WATERMAN AVE</u>				10		
3. NAME OF DECEASED (Type or Print) a. (First) <u>TERESA</u>			b. (Middle) _____			c. (Last) <u>HESTER</u>				
4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 22-1949</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>DEC. 8th 1975</u>		
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>U</u>	
13a. FATHER'S NAME <u>JOHN T. HESTER</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH MAHER</u>			14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Nellie Mullen</u>				ADDRESS <u>3804 Jennings Rd.</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>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterosclerotic heart dis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>None</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>ST. LOUIS</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>ASFD</u>								
22. I hereby certify that I attended the deceased from <u>Nov 15</u> , 19 <u>49</u> to <u>July 22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>49</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <u>Delmar McArthur M.D.</u>				23b. ADDRESS <u>506 No. Hester Bldg.</u>				23c. DATE SIGNED <u>July 22, '49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JULY 25-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>				
DATE REC'D BY LOCAL REG. <u>JUL 23 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Laster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Mullen Und Co.</u>		ADDRESS <u>Delmar Be. 5165</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed T. G. Farris

Signed _____
Student Embalmer

Licensed Embalmer No. 3384

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.