No. 300
10.48

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

FILED JUL 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26403

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6304

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS, Mo
c. LENGTH OF STAY (in this place): 9 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LOUIS CHILDREN'S

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: ILLINOIS
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GEFF
d. STREET ADDRESS (If rural, give location): ROUTE #2

8120

3. NAME OF DECEASED (Type or Print)
a. (First): BETTY
b. (Middle): JEAN
c. (Last): TETRICK

4. DATE OF DEATH (Month) (Day) (Year): 6-30-52

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 6-7-45
9. AGE (In years last birthday): 7 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): McKEON, OHIO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: TOM H. TETRICK
13b. MOTHER'S MAIDEN NAME: JEAN WADLINGTON
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: J. EGAN — **ADDRESS**: 500 So. Kings Highway

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Monocytic Leukemia — Interval between onset and death:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

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) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

2042

22. *I hereby certify that I attended the deceased from* 6-21, 1952, *to* 6-30, 1952, *that I last saw the deceased alive on* 6-30, 1952, *and that death occurred at* 5:20 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm G Klingberg (Degree or title): MD
23b. ADDRESS: St. Louis Childrens
23c. DATE SIGNED: 6-30-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6-30-52
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Cisne, Ill.

DATE REC'D BY LOCAL REG.: JUL 1 1952
REGISTRAR'S SIGNATURE: J Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS**: Albert H. Hoppe, 4500 Washington Blvd.

mgB (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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Ellen R H Remelius

Licensed Embalmer No. 4283

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.