

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36921**
Registrar's No. **9111**

FILED OCT 21 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 2 days		d. STREET ADDRESS (If rural, give location) 3416 Illinois	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Lillian b. (Middle) B. c. (Last) Teckas		4. DATE OF DEATH (Month) (Day) (Year) 9/29/52	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/20/1885
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Fredericktown, Mo.
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME E. W. Sheppard	13b. MOTHER'S MAIDEN NAME Mary Stephens	14. NAME OF HUSBAND OR WIFE Louis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Louis Teckas--3416 Illinois

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH yes yes
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Myocardial		
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 <input type="checkbox"/> NO <input 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) (STATE)
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 4221

22. I hereby certify that I attended the deceased from **July 1, 1952** to **Sept 29, 1952**, that I last saw the deceased alive on **Sept 29, 1952**, and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE D. S. Hume M.D.	(Degree or title)	23b. ADDRESS 2752 Cherokee	23c. DATE SIGNED Sept 30-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/2/52	24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	24d. LOCATION (City, town, or county) (State) Flat River, Missouri
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DATE REC'D BY LOCAL REG. OCT 1 1952	REGISTRAR'S SIGNATURE J. C. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldner	ADDRESS 3634 Gravois
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(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.

Student
Student Embalmer

Signed

Robert Wheeler

Licensed Embalmer No. *3128*

P. O. Address *Levin's 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.