

STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 4 1953

BIRTH NO. ... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2990

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
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) 12 days		2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		d. STREET ADDRESS (If rural, give location) 4747 Milentz Avenue	

3. NAME OF DECEASED (Type or Print) TINSLEY,		a. (First) ANNE		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 3 17 1953	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH February 20th. 1878		9. AGE (In years last birthday) 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Joseph Fuglein		13b. MOTHER'S MAIDEN NAME Barbara ?		14. NAME OF HUSBAND OR WIFE Widow	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie Murphree 4382 Forrest Park	
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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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		DUPLICATE				years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis						years	
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 checked="" type="checkbox"/>	
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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)	
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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? 4200	
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22. I hereby certify that I attended the deceased from March 6, 1953, to March 17, 1953, that I last saw the deceased alive on March 17, 1953, and that death occurred at 7:25 P.m., from the causes and on the date stated above.

23a. SIGNATURE George Esker, M.D.		23b. ADDRESS 5600 Arsenal St.		23c. DATE SIGNED 3/18/53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 20th. 1953		24c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
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DATE REC'D BY LOCAL REG. MAR 19 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY L. WEIDEMUELLER 6203 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

John R. Harris

.....
Licensed Embalmer No. *4107*

P. O. Address *St. Louis, 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.