

FILED DEC 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43991**
10935
Registrar's No.

BIRTH NO. <u>93263-56</u>		REG. DIST. NO. <u>318</u>	PRIMARY REG. DIST. NO. <u>1003</u>	Registrar's No. <u>10935</u>
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>201 1/2 2241 WARREN</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>JEFFREY</u> b. (Middle) <u>LYNN</u> c. (Last) <u>TIFFENAUER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 28 - 56</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>11-26-56</u>	9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> IF UNDER 12 HRS. Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ALBERT W. TIFFENAUER</u>		
13b. MOTHER'S MAIDEN NAME <u>BEVERLEY STEVENS</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) <u>No. Nil.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>BEVERLEY TIFFENAUER, 2241 WARREN.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pericardial effusion & heart failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute pericarditis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>754.4</u>		20. AUTOPSY? YES <input checked="" 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) (Min.)		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>11-26, 1956</u> , to <u>11-28, 1956</u> , that I last saw the deceased alive on <u>11-28, 1956</u> , and that death occurred at <u>8:03 A. M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Samuel W. Jollub M.D.</u>		23b. ADDRESS <u>4500 Olive</u>		23c. DATE SIGNED <u>Nov. 29, 56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11-28-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Caledonia, Mo.</u>
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington,</u>		
DATE REC'D BY LOCAL REG. <u>NOV 29 1956</u>		REGISTRAR'S SIGNATURE <u>Charles Smith M.D.</u> <i>mjs</i>		

(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.....
Signature of Student Embalmer

Signed *E. C. ...*

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.