

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 10 1957

15379  
STATE FILE NUMBER 1186

Registration District No. 318 Primary Registration District No. 1003 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, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		d. STREET ADDRESS <u>2001 Maury Ave.</u>	
Length of stay in lb <u>5-wks.</u>		(If outside, give location) <u>17</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>G.</u> Last <u>Tissot</u>			4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1907</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Composer, Sterling Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Switzerland</u>	
13. FATHER'S NAME <u>George Tissot</u>			14. MOTHER'S MAIDEN NAME <u>Louise Schneeberger</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War # 2</u>	16. SOCIAL SECURITY NO. <u>489-07-4259</u>	17. INFORMANT Address <u>Mr. Gilbert Tissot, 2001 Maury Ave.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
DUE TO (b) <u>Metastases to left kidney, pelvic glands</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.	<u>154x</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>4-20-50</u> to <u>5-2-57</u> and last saw <del>him</del> <u>her</u> alive on <u>5-2-57</u>		
Death occurred at <u>10:10 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>James P. Murphy, M.D.</u>	22b. ADDRESS <u>634 North Grand Blvd.</u>	22c. DATE SIGNED <u>5-2-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>May 6, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>	ADDRESS <u>3040 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 2 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

S.P.

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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  .....  
Licensed Embalmer No. 469

P. O. Address 5870

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.