

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027510  
STATE FILE NUMBER

FILED AUG 7 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 7221

S. 300  
1-57

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY <i>St. Louis</i>                       |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Webster Groves, Mo  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>St. Louis-Little Rock Hospitals, Inc.</i>   |  | Length of stay in 1b<br>6 days  | d. STREET ADDRESS (If outside, give location)<br>418 Summit Ave.                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Mary Louise Tiefenbrunn   |  |   | 4. DATE OF DEATH<br>Month Day Year<br>July 21, 1958   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>March 1, 1875   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housework  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>At Home  | 11. BIRTHPLACE (City and state or country)<br>Mine Lamotte, Mo.                                   |
| 13a. FATHER'S NAME<br>Thomas Flieg  |  | 13b. MOTHER'S MAIDEN NAME<br>Louise Kiefer  | 14. NAME OF HUSBAND OR WIFE<br>Late William Tiefenbrunn   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give years of service)<br>None None  |  | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT Address<br>Isabel M. Lins 418 Summit Ave.   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of the Gall Bladder with Metastasis  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>6 mo.   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   | 155-1   |
| 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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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<br>Hour Month, Day, Year<br>o.m.<br>p.m.  |  |   |   |
| 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 July 16, 1958 to July 21, 1958 and last saw her alive on July 21, 1958<br>Death occurred at 3:05 pm m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE <i>L. B. Harrison</i> (Degree or title)  |  | 22b. ADDRESS<br>1755 So. Grand Blvd.  | 22c. DATE SIGNED<br>7-22-58   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 23b. DATE<br>July 24, 1958   | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery  | 23d. LOCATION (City, town, or county) (State)<br>St. Louis, Mo.                                   |
| 24. FUNERAL DIRECTOR<br>Kriegshauser Mortuary - St. Louis, Mo.  |  | 25. DATE RECD. BY LOCAL REG.<br>JUL 22 '58  | 26. REGISTRAR'S SIGNATURE<br><i>J. Carl Smith</i>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Richard W. Storr* .....

Licensed Embalmer No. *4007* .....

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