

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034755

STATE FILE NUMBER

REC OCT 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9326

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Velda Village 4000</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Length of stay in lb <b>LIFE</b>	d. STREET ADDRESS (If outside, give location) <b>6520 Perry Court 20</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BUELLA</b> Middle <b>CARRIE</b> Last <b>TETTENHORST</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>25</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1901</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Bussmann Mfg. Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Henry W. Tettenhorst</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Gronemeyer</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Estelle Schulze</b>	Address <b>6520 Perry Court</b>
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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) <b>Gastrointestinal hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
DUE TO (b) <b>Abdominal carcinomatosis</b>		
DUE TO (c) <b>Adenocarcinoma of sigmoid colon</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>(1) Large Carcinoma on sigmoid colon</b> <b>(2) Metastatic carcinoma to liver</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>1</b>
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20a. ACCIDENT: 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <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 <b>Clayton</b>	COUNTY <b>Carondelet</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>12-13-1948</b> to <b>9-25-1958</b> and last saw <b>her</b> alive on <b>9-25-1958</b> Death occurred at <b>7:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>James G. Briggs, M.D.</b> (Degree or title)	22b. ADDRESS <b>7820 Carondelet Clayton</b>	22c. DATE SIGNED <b>9-27-1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Calvin F. Feutz</b>	ADDRESS <b>4828 Natural Bridge</b>	25. DATE RECD. BY LOCAL REG. <b>9-29-1958</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Ralph L. Finck.....

Licensed Embalmer No. 4275.....

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