

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003580  
STATE FILE NUMBER

1003

89

FILED JAN 26 1959

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

S. 300  
1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 7169 ADDRESS 4223a Humphrey	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE (MARIA) NMN TILLINGER		4. DATE OF DEATH Month Day Year JANUARY 3, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 18, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Men's Tailoring Shop-Stix, Baer & Fuller		10b. KIND OF BUSINESS OR INDUSTRY Yugoslavia	11. BIRTHPLACE (City and state or country) 6 U.S.A.
13a. FATHER'S NAME Stefan Truba		13b. MOTHER'S MAIDEN NAME Katherina Fessel	14. NAME OF HUSBAND OR WIFE Joseph Tillinger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give name or dates of service) None		16. SOCIAL SECURITY NO. 498-36-0533	17. INFORMANT Address Joseph Tillinger 4223a Humphrey
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MONOCYTIC LEUKEMIA  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 204.2  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
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.		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 COUNTY STATE	
21. I attended the deceased from DEC. 1, 1958 to JAN. 3, 1959 and last saw her alive on JAN. 3, 1959 Death occurred at 7:35 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Thayer M. D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. JAN 5 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>

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. Stovesund* .....

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.