

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

79-007935
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 457

1. PLACE OF DEATH
a. COUNTY ST. LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST. LOUIS

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND HEIGHTS Inside Limits Yes No

c. CITY OR TOWN ST. JOHN 4201 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S Length of stay in lb 2 DAYS

d. STREET ADDRESS 8640 ST. CHAS. RE. RD. Reside on Form Yes No

3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE ANGIE TEBEAU

4. DATE OF DEATH Month Day Year FEB 14 1959

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH SEPT. 25, 1916 9. AGE (In years last birthday) 42 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (City and state or country) FLORISSANT, MO. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME LEON GEREAU 13b. MOTHER'S MAIDEN NAME ANGIE MURRAY 14. NAME OF HUSBAND OR WIFE ALVIN L.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war and dates of service) 16. SOCIAL SECURITY NO. 492-34-7601 17. INFORMANT ALVIN L. TEBEAU, 8640 ST. CHAS. RD., ST. JOHN Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE INTERVAL BETWEEN ONSET AND DEATH 38 HRS.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 330x 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 2-13-59 to 2-14-59 and last saw her alive on 2-14-59. Death occurred at 10:35 pm. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Martin L. Cushman Degree of title 22b. ADDRESS 634 N Grand Blvd 22c. DATE SIGNED 2-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 2-18-1959 23c. NAME OF CEMETERY OR CREMATORY ST. FERDINAND'S 23d. LOCATION (City, town, or county) (State) FLORISSANT, MO.

24. FUNERAL DIRECTOR VITE FLORISSANT MORTUARY, ADDRESS FLORISSANT, MO. 25. DATE RECD. BY LOCAL REG. 2-17-59 26. REGISTRAR'S SIGNATURE John C. Murphy, M.D./M

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300
1-57

REC'D FEB 24 1959

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 *Gene Sputchens*

Licensed Embalmer No. *4966*

P. O. Address *Flourish, N.*

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.