

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011450  
STATE FILE NUMBER  
2365

FILED MAR 25 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 3 HOSPITAL OR INSTITUTION <i>CITY HOSPITAL</i>		Length of stay in 1b <i>DOA</i>	
d. STREET ADDRESS <i>4132 TESSON</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <i>JEAN E TEXIER</i>			4. DATE OF DEATH Month Day Year <i>MARCH 4 1959</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 24, 1927</i>
9. AGE (In years last birthday) <i>31</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>MILWAUKEE, WISC.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13a. FATHER'S NAME <i>ARTHUR H FRIESE</i>	
13b. MOTHER'S MAIDEN NAME <i>ELSIE A TELLMAN</i>		14. NAME OF HUSBAND OR WIFE <i>OSCAR WM. OR WM. O.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>OSCAR WM. OR WM. O. TEXIER 4132 TESSON</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation</i>			INTERVAL BETWEEN ONSET AND DEATH
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 (Do not include the terminal stage condition of (a).) <i>Her dog and hangings fell in basement of home on March 4, 1959 about 1:48 p.m. While suffering temporary mental aberration</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, PART I or PART II of item 18.) <i>As above</i>		
20c. TIME OF INJURY Hour Month, Day, Year <i>11:18 p.m. 3 4 59</i>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St. Louis Mo</i>		
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated		22a. SIGNATURE (Do not sign title) <i>James J. [Signature]</i>	
22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>3/7/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>3/9/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 7 - 59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

CB

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 *Donald E. Benz* .....

Licensed Embalmer No. *4863* .....  
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.