

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-034398

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2 8063**

RENDERED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		a. STATE Missouri		b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Year <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS (If outside, give location) 952 Harlan Ave.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last TESSON				4. DATE OF DEATH Month August Day 29th Year 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 5/15/88	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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 at home		11. BIRTHPLACE (City and state or country) Perry Co., Ill.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Eichholz			13b. MOTHER'S MAIDEN NAME Katherine Boemmershine		14. NAME OF HUSBAND OR WIFE Philip C. Tesson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 488-09-8817	17. INFORMANT Philip C. Tesson, 952 Harlan Ave., Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Carcinoma of Stomach							6 wks +
SECONDARY Arteriosclerotic							
DUE TO (b) Heart Disease							3 yrs +
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. 151x <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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 1952 to Aug 29/59 and last saw her ^{her} _{him} alive on Aug 29 1955 Death occurred at 10:00 P on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert J. Sarasonch M.D.				22b. ADDRESS 321 N. Bldg		22c. DATE SIGNED 9/3/59 (State)	
23a. BURIAL CREMATION, REMOVAL (Specify) burial	23b. DATE 9/2/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.			
24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallsferry ADDRESS			25. DATE RECD. BY LOCAL REG. AUG 31 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. ms		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

By _____

Signature of _____

Signature of _____

x

x

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 J. W. M. B. Embler

Licensed Embalmer No. 8053

P. O. Address St. Louis

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.