

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JUL 22 1960**

**-60-028863**

ENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6730** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MADISON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		Length of stay in 1b <b>DOA</b>		c. CITY OR TOWN <b>COLLINSVILLE</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>LUTHERAN HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>400 SOUTH ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS JOHN TEYLER</b>				4. DATE OF DEATH Month Day Year <b>JULY 3 1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/29/45</b>	9. AGE (last birthday) <b>14</b>	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) <b>STUDENT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		11. BIRTHPLACE (City and state or country) <b>DANVERS, ILL</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>THEODORE W. TEYLER</b>			13b. MOTHER'S MAIDEN NAME <b>MARGARET MATTHES</b>		14. NAME OF HUSBAND OR WIFE <b>NEVER MARRIED</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>THEO W. TEYLER</b>		Address <b>ILL. COLLINSVILLE</b>		
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>Acute Lymphatic Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		<b>2043</b>		
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. <input type="checkbox"/> Yes <input 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 Month, Day, Year a.m. p.m.								
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 <b>9/59</b> to <b>7/3/60</b> and last saw <sup>her</sup> him alive on <b>6/29/60</b> Death occurred at <b>7/7/60</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Frede Mortensen, M.D.</b>				22b. ADDRESS <b>3701 Grandel Sq St Louis 8 MO</b>			22c. DATE SIGNED <b>7/4/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>7/7/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CEMETARY COLLINSVILLE ILLINOIS</b>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR <b>HERR FUNERAL HOME</b>			ADDRESS <b>COLLINSVILLE ILLINOIS</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 5 1960</b>		26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*W. H. Smith*

Licensed Embalmer No. 3577

P. O. Address Collinsville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.