

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

-60-040445

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3023 STATE FILE NUMBER

| | | | | | | | |
|---|---|--|---|---|---|--|----------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>St. Louis</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | c. CITY OR TOWN <u>Kirkwood</u> | | d. STREET ADDRESS (If outside, give location) <u>551 N. Clay</u> | |
| Length of stay in lb <u>32 Yrs.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First <u>WALTER</u> | | Middle <u>ADOLPH</u> | | Last <u>TELLE</u> | | Month <u>10</u> Day <u>16</u> Year <u>60</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/8/1895</u> | 9. AGE (last birthday) <u>65</u> | IF UNDER 1 YEAR | | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Firekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Independent Pack Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Gotthilf Telle</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Bertha Landl</u> | | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth Telle</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>489-07-0346</u> | | 17. INFORMANT <u>Elizabeth Telle</u> Address <u>Kirkwood, Mo. 551 N. Clay</u> | | | |
| 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) <u>myocardial infarction</u> | | | | | | <u>ONE HOUR</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis</u> | | | | | | | |
| 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. | | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>10:15</u> 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 <u>1950</u> to <u>present</u> and last saw <u>him</u> alive on <u>Sept 15, 1960</u> . Death occurred at <u>10:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Robert C. Hengeland MD</u> (Degree or title) | | | | 22b. ADDRESS <u>14 FORSYTH WALK CLAYTON S. MO</u> | | 22c. DATE SIGNED <u>10-16-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10/19/1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>Pfizinger Mort., Kirkwood, Mo</u> ADDRESS | | | 25. DATE RECD. BY LOCAL REG. <u>10-18-60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> | | | |

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. _____
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.