

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 12 1940

701

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

41727

10850

Registration District No.

1002

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Mo. 2  
 (b) City or town ST LOUIS.  
 (c) Name of hospital or institution: 4131 MAFFITT. AVE  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1  
 (c) City or town ST LOUIS. 11  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4131 MAFFITT. AVE  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME LUELLA SARAH TESSON. 250

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED.  
 6. (b) Name of husband or wife GEORGE L. TESSON. 6. (c) Age of husband or wife if alive UNK years  
 7. Birth date of deceased OCT. 18. 1890.  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17  
 year 1939 hour 8 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from Jan 2, 1938, to Dec 17, 1939  
 that I last saw her alive on Dec 17, 1939  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Cerebral Apoplexy Duration 2 days

Due to Hypertension of eyes

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature John J. Kehoe (M. D. or other) 11/1/39  
 Address 4145 St. Louis Date signed \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>49.</u>	<u>1</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME.

11. Industry or business \_\_\_\_\_

12. Name WILLIAM H. NEALY.

13. Birthplace Mo. (City, town, or county) (State or foreign country)

14. Maiden name CATHERINE HOBAN. (City, town, or county) (State or foreign country)

15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Luella S. Tesson

(b) Address 4131 MAFFITT AVE

17. (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof DEC. 20<sup>th</sup> 1939. (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY.

18. (a) Signature of funeral director L. M. Muller.

(b) Address 5165 DELMAR BLVD.

19. (a) DEC 20 1939 (Date received local registrar) (b) \_\_\_\_\_ (Signature)

**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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed

*John Ketter*

Licensed Embalmer No. 3880

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 this body is not embalmed, above space should be left blank.**