

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED JUN 4 1945
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME **Charles V. Tuxhorn**

3. (b) If veteran, name war **Nil**

3. (c) Social Security No. **334-01-9619**

4. Sex **Male** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Margaret Tuxhorn**

6. (c) Age of husband or wife if alive **53** years

7. Birth date of deceased **November 3 1885**
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	6	18	hr. min.

9. Birthplace **Edwardsville Illinois**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Charles F. Tuxhorn**

13. Birthplace **Edwardsville Illinois**
 (City, town, or county) (State or foreign country)

14. Maiden name **Anna K. Veal**

15. Birthplace **Unknown Germany**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Albert H. Tuxhorn**

(b) Address **Edwardsville, Ill.**

17. (a) Removal **Removal** **(b) Date thereof** **5-22-45**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Edwardsville, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **MAY 22 1945** **(b) J. F. Bredech**
 (Date received local registrar) (Registrar's signature)

2. USUAL PLACE OF DECEASED:

(a) State **Illinois** (b) County **Madison**

(c) City or town **Edwardsville**
 (If outside city or town limits, write "RURAL")

(d) Street No. **2**
 (If rural, give location)

(e) Citizen of foreign country? **2** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **21**
 year **1945** hour **1:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **March 27**
1945, to **May 21** **1945**;
 that I last saw him alive on **May 21** **1945**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinomatosis** **3 mo**

Due to **Carcinoma of bladder & urinary** **6 mo**

Due to **52**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **52**

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 **Albert H. Hoppe** **(M. D. or other)**

Address **4700 Washington Blvd.** **Date signed** **May 22 1945**

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed Albert G. Hoops

Licensed Embalmer No..... 2971

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 this body is not embalmed, fact should be so stated above.