

DEPARTMENT OF COMMERCE 7 1945 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26196
Registrar's No. 7469

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hosp # 1
(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)

3. (a) PRINT FULL NAME Goerge L Tearne

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Nov 9 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Cleaner

11. Industry or business Ideal Cleaning Co

12. Name Walter Tearne

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

14. Maiden name Elizabeth Glenwill

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

16. (a) Informant Rose Tearne

(b) Address 4403 Arco Ave

17. (a) Burial (b) Date thereof 8 30 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) AUG 28 1945 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4403 Arco Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27
year 1945 hour 10.00 AM minute 44

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death
Primary Occlusion
Coronary Artery

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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)
Means of injury _____
23. Signature [Signature] M. D. or other _____
Date signed 8/28/45

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

CO
17
9

MOTHER FATHER

874

Coroner's Case

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 Edwin P. Mc Dermott

Licensed Embalmer No. 3024

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.