

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32437

State File No. ....

FILED NOV 18 1945

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 9505

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:  
St. Louis City Hospital-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
(Specify whether  
 In this community 32 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County.....  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3214 A Minnesota  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME OLIVER TEDFORD  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31st  
 year 1945 hour 10:30 minute P. M.  
 21. I hereby certify that I attended the deceased from 10/24/45  
 19... to 10/31/45 19...  
 that I last saw him im alive on 10/31/45 19...  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Margaret 6. (c) Age of husband or wife if alive 58 years  
 7. Birth date of deceased May 17 1880  
(Month) (Day) (Year)

Immediate cause of death Multiple Myeloma  
 Duration  
 Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
65 5 14 hr. min.

9. Birthplace Mo  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Salesman

MOTHER FATHER  
 11. Industry or business  
 12. Name James Tedford  
 13. Birthplace Mo  
(City, town, or county) (State or foreign country)  
 14. Maiden name Alice Powell  
 15. Birthplace Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Major findings:  
 Of operations.....  
 Of autopsy.....  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Margaret Tedford  
 (b) Address 3214 A Minnesota  
 17. (a) Burial (b) Date thereof Nov 3 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation S. St. Peter/Paul Cem

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?

18. (a) Signature of funeral director Herbert C. Fritz  
 (b) Address 2906 Gravois  
 19. (a) NOV 2 1945 (b) J. Tedford  
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)  
 (c) Means of injury.....  
 23. Signature Herbert C. Fritz (M, P, or other)  
 Address 1515 Lafayette Date signed 11/1/45

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

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

*David Lee Forsman*

Licensed Embalmer No. *4242*

P. O. Address *2906 Main*

**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.**