

S. No. 2  
M-5-43  
5-17-39  
X38671

FILED OCT 28 1946 318 1003

State File No. \_\_\_\_\_  
Registrar's No. 8921

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Louis Mo  
(b) City or town St. Louis Mo  
(c) Name of hospital or institution:  
221-a-S B'way  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME Jess Tausen Tesser  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color White  
6. (b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unk unk unk  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
unk unk unk unk hr. min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Thos T Pallanan  
(b) Address 1300 Clark

17. (a) Burial (b) Date thereof 10/18/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
19. (a) OCT 18 1946 (Date received local report) J. J. Bredeen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(d) Street No. 221-a S B'way  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: 1946 month Sept day 29  
year hour minute 50 am  
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 \_\_\_\_\_  
Due to Cardiac Hypertrophy  
Due to Hydro-Thorax Right Side  
Other conditions: H.M.A.  
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 \_\_\_\_\_  
Signature Robert E. Taylor (M.D. or other)  
Address \_\_\_\_\_ Date signed 10/18/46

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

1268

No Embalm

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**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.....

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