

No. 2
1-5-43
5-17-39
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FILED NOV 12 1946
318

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **Jk. Lewis Mo**
 (b) City or town **City of St. Louis**
 (c) Name of hospital or institution **St. Louis #10**
 (d) Length of stay: In hospital or institution **10**

In this community **Frank Teller**
 years, months or days

3. (a) PRINT FULL NAME **Frank Teller**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color **White**

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

6. (c) Age of husband or wife if alive **47 1/2**

7. Birth date of deceased **Nov 18 1898**

8. AGE	Years	Months	Days	If less than one day
57	84			

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

10. Usual occupation **Wink**

11. Industry or business **Wink**

12. Name **Wink**

13. Birthplace **Wink**

14. Maiden name **Wink**

15. Birthplace **Wink**

16. (a) Informant **Thos. J. Callahan**

(b) Address **2310 Stark**

17. (a) **BURIAL** (Burial, cremation, or removal)

(b) Date thereof **11-1-46**

(c) Place: burial or cremation **CITY CEMETERY**

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

(b) Address **4700 W. Washburn**

19. (a) **NOV 1 1946** (Date received local Registrar's)

J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**

(c) City or town **Jk. Lewis Mo**

(d) Street No. **2577**

(e) Citizen of foreign country? **No**

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **18** year **1946** hour **4** minute **15** M.

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: **1. Subdural Hemorrhage 2. Brain 2. External hemorrhage from Ruptured Spleen. Coronary Artery Due to Atherosclerosis. Walked into the side of truck driven by one George Patterson, 601 W. Walnut St. Intervention of Dr. F. Walcott, Jr.**

Other conditions: **Arteriosclerosis**

(Include pregnancy within 3 months of death)

Major findings: **Unavoidable accident**

Of operations _____

Of autopsy _____

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) **Unavoidable Accident**

(b) Date of occurrence **Oct. 11, 1946**

(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)

(c) Manner of injury **2**

23. Signature **Thos. J. Callahan** (Date signed) **11/1/46**

No Embalming

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.

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25-41
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Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **9343**

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(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 City Hospital #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 Frank Fuller

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

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

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years abt - 84 Months _____ Days _____ If less than one day _____ 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 _____

(b) Address _____

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

(c) Place: burial or cremation Assigned to the Anatomical Board - 11-1-1946

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 11-1-1946 (b) J. F. Bredenkamp
(Date received local registrar) (Registrar's signature)

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. 5th St. 9th St
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Oct day 18
year _____ hour _____ minute _____ M.

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 _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

DEC 17 1946

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