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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11596**
Registrar's No. **2483**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis Missouri**
(b) City or town **St. Louis Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community **Life.** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Mabel A. Talleur**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **William L.** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **June 8th, 1898**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 9 23 hr. min.

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

10. Usual occupation **At home**

11. Industry or business _____

12. Name **George Tepe**

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

14. Maiden name **Anna M. Bohlen**

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

16. (a) Informant **William L. Talleur**

(b) Address **4990 Quincy**

17. (a) **Burial** (b) Date thereof **4/3/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cem.**

18. (a) Signature of funeral director **J. L. Ziegenhein**

(b) Address **2027 Gravois Ave.**

19. (a) **APR 2 1947** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **217**
(If outside city or town limits, write "RURAL")
(d) Street No. **4990 Quincy St.** **9**
(If rural, give location) **0**
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31st**,
year **1947** hour **2** minute **15** P. M.
21. I hereby certify that I attended the deceased from **3-25-47**
_____ 19____, to **3-31**, 19**47**
that I last saw h. **ev.** alive on **3-31-47**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal obstruction** Duration **3 days**

Due to **Carcinoma recto sigmoid** **6 mos.**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **Hb.**

Major findings: Of operations **as above**

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 **E. A. Vogel** (M. D. or other) **0**

Address **3325 S. Grand** Date signed **4-1-47**

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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Hawaii*

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.