S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

36324
State File No. 9510

FILED OCT 24 1947
Registration District No. 9818 Primary Registration District No. 1003
Registrar's No.

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

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. 307 S. Euclid Av.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sister Mary Raymond Tesson RSM
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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. (Month) 16 (Day) 1845 (Year)

8. AGE: Years	Months	Days	If less than one day
51	10	28	hr. min.

9. Birthplace Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Religious
11. Industry or business
FATHER 12. Name Charles Tesson
13. Birthplace Mo. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Alice Murphy
15. Birthplace Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Sister M. Hommick
(b) Address 307 S. Euclid Av.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation Mercy Convent Cem.
18. (a) Signature of funeral director J. H. Mullen
(b) Address 5765 Delmar Bl.
19. (a) OCT 14 1947 (Date received local registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 13 year 1947 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from January, 1947, to October 13, 1947; that I last saw her alive on October 13, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lymphosarcoma (Large cell type)	Jan. 1947+
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Bernard T. Kane (M. D. or other) MD
Address 4755 Magnolia Road St. Louis 16, Mo. Date signed 10/14/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Mr. Bernard Kaon

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 J. G. Fanis

Licensed Embalmer No. 3384

P. O. Address St. Louis.

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.