

1003  
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39  
1906

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

FILED JUN 28 1948 318

State File No. \_\_\_\_\_

5500

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

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County 000  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3637 Hickory St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME KATHERINE TESZAR  
(b) If veteran, \_\_\_\_\_ (c) Social Security name war \_\_\_\_\_  
4. Sex FE 1. Color or race W  
5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife JOHN TESZAR  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased NOVEMBER 22 - 1890  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 16  
year 1948 hour \_\_\_\_\_ minute 00 p.m.  
21. I hereby certify that I attended the deceased from May 20 1948 to June 16 1948  
that I last saw her alive on June 16 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 6 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of Breast  
Due to Breast  
Due to \_\_\_\_\_

9. Birthplace CINCINNATI Ohio  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 50

10. Usual occupation HOUSEKEEPER  
11. Industry or business OWN  
12. Name JOHN O'HALLORAN  
13. Birthplace IRELAND  
(City, town, or county) (State or foreign country)  
14. Maiden name BRIDGET GATELY  
15. Birthplace IRELAND  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mr John Teszar  
(b) Address 3637 Hickory St  
17. (a) BURIAL (b) Date thereof JUNE 19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CALVARY CEM.  
18. (a) Signature of funeral director E. J. Schurer  
(b) Address 3125 Lafayette Ave.  
19. (a) JUN 17 1948 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature J. F. Bredek (M. D. \_\_\_\_\_)  
Address 1446 So. Grand Date signed 6/17/48

**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 John B. Hollman

Licensed Embalmer No. 4114

P. O. Address 3125 Lafayette Ave

**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.**