

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28779**
Registrar's No. **7744**

FILED SEP 13 1951

318

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY /		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3931a McRee Ave.		d. STREET ADDRESS (If rural, give location) 3931a McRee Ave. 0	

3. NAME OF DECEASED (Type or Print) Dora Tecklenburg			4. DATE OF DEATH (Month) (Day) (Year) Aug. 30, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April 16, 1862	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Mascoutah, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Frederick Jenning		13b. MOTHER'S MAIDEN NAME Henrietta Salo		14. NAME OF HUSBAND OR WIFE Jacob W.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Dora McHattie, 3931a McRee	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7-5 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Myocarditis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Senility		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4221	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. [INJURY] OCCURRED WHILE AT [] NOT WHILE AT WORK []		21f. HOW DID INJURY OCCUR? FAH	

22. I hereby certify that I attended the deceased from **24-July 1951**, to **30-Aug, 1951**, that I last saw the deceased alive on **30-Aug, 1951**, and that death occurred at **5:10p** m., from the causes and on the date stated above.

23a. SIGNATURE: [Signature] (Degree or title) MD		23b. ADDRESS: 4501^a Manchester		23c. DATE SIGNED: 31 Aug 51	
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE 9-1-51		24c. NAME OF CEMETERY OR CREMATORY Valhalla	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			

WRITE PLAINLY—USING UNFADEING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

John J. Harris

Licensed Embalmer No. *4108*

P. O. Address *J. Harris, D. Me.*

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.