

No. 300
0-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1954

State File No. **3344**
Registrar's No. **0274**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY 0		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 township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) _____		e. STREET ADDRESS (If rural, give location) 4349a Shaw Ave. 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarinate Word Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Earl	c. (Last) Teigraver	4. DATE OF DEATH (Month) (Day) (Year) Jan. 10, 1954
-------------------------------------	---------------------------	-------------------------	----------------------------	---

5. SEX 0 Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 5, 1889	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	Hours _____	Min. _____
--------------------------------	----------------------------------	--	---	---	------------------------------	-----------------------------	-------------	------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.
--	--	---	---

13a. FATHER'S NAME Frank Teigraver	13b. MOTHER'S MAIDEN NAME Elizabeth Cowan	14. NAME OF HUSBAND OR WIFE Hazel
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hazel Teigraver, 4349a Shaw Ave.
---	---	--

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephrosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cancer of prostate		Interval between onset and death: Autopsy?	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 446X
--	--	---

22. I hereby certify that I attended the deceased from **20 Dec, 1953**, to **10 Jan, 1954**, that I last saw the deceased alive on **9 Jan, 1954**, and that death occurred at **12:40 AM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. D. Sheahan M.D.	23b. ADDRESS 1657 So Grand Blvd	23c. DATE SIGNED 11 Jan 54
---	---	--------------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) Removal	24b. DATE 1-12-54	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
--	-----------------------------	--	--

DATE REC'D BY LOCAL REG. JAN 11 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrigan-Sheahan, 4700 Washington Blvd
--	--	---

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, ~~by~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elton R. Penick*

Licensed Embalmer No. *42*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.