

FILED OCT 8 1956

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

30448

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 867-A

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Bexar</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>San Antonio</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Medical Center For Federal Prisoners</u> | | | Length of stay in lb <u>1109 Days</u> | d. STREET ADDRESS (If outside, give location) <u>Unknown</u> | | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Van</u> Middle <u>Archer</u> Last <u>Teufel</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>21</u> , Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>12-12-1900</u> | | 9. AGE (In years last birthday) <u>55</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Notions</u> | 11. BIRTHPLACE (City and state or country) <u>Winthrop, Arkansas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Adam Teufel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Davis</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT <u>FILE: MCFP Springfield, Missouri</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) <u>Bronchopneumonia</u> | | 2 months | | |
| | | | DUE TO (c) <u>Pseudosclerosis</u> ✓ | | <u>3 5/8</u> years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ***** | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ***** | | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ | | | ***** | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ***** | | 20f. CITY, TOWN, OR LOCATION ***** | | COUNTY _____ STATE _____ | |
| 21. The medical staff <u>11-12-52</u> to <u>9-21-56</u> and last saw him <u>him</u> alive on <u>9-21-56</u> attended the deceased from <u>11-12-52</u> to <u>9-21-56</u> Death occurred at <u>4:45</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | 22b. ADDRESS <u>Medical Center For Federal Prisoners, Springfield</u> | | 22c. DATE SIGNED <u>9-25-56</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9/27/56</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u> | | 23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u> | | | |
| 24. FUNERAL DIRECTOR <u>Ayre-Goodwin</u> | | | ADDRESS <u>Springfield, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>10-1-56</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be stated.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
-56Health,
Welfare
Public
Service

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

Student.....
Signature of Student Embalmer

Signed.. *Charles A. Roof*

Licensed Embalmer No. *30*

P. O. Address *Wm. Hill*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.