

COUNTRY

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32800**

ANNAPOLIS, Md.
FILED OCT 8 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2061**

1. PLACE OF DEATH a. COUNTY St Louis		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 Koch		c. LENGTH OF STAY (in this place) 2 1/2 mos	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		e. STREET ADDRESS (If rural, give location) 202 Pine	
3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) Tennell c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) aug 24 56	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 9-17-90
9. AGE (In years last birthday) 65		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) Domestic Servant		10b. KIND OF BUSINESS OR INDUSTRY Serving	11. BIRTHPLACE (City and State or Foreign Country) Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Elmer Tennell	
13b. MOTHER'S MAIDEN NAME Mary Anna Jones		14. NAME OF HUSBAND OR WIFE Divorced	
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. Unk.	17. INFORMANT'S SIGNATURE OR NAME Patients Record ADDRESS _____
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis, pulmonary ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 8-20-56		19b. MAJOR FINDINGS OF OPERATION Empyema - Broncho pleural Fistula	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 6-19 , 19 56 , to 8-24 , 19 56 , that I last saw the deceased alive on 8-24 , 19 56 , and that death occurred at 9:55 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Bened Teuaman		23b. ADDRESS (Degree or title) M.D. Koch Hosp, Koch, Mo.	
23c. DATE SIGNED 8-25-56		24a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical	
24b. DATE 8-31-56		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		25. Rowland Baker Mortuary Service ADDRESS 4101 Manchester Ave. St. Louis 10, Mo.	
DATE REC'D BY LOCAL REG. 8-31-56		REGISTRAR'S SIGNATURE Herbert B. Dombek	

WRITE PLAINLY—USING UNFADING 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, Student Embalmer No.....
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *No Embalmer*
[Signature]
Licensed Embalmer No.....

P. O. Address

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.