

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003782

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No.

317

Primary Registration District No.

542

Registrar's No.

98

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson 4000 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hill Top Nu, Home		Length of stay in lb 6 Mo.	d. STREET ADDRESS (If outside, give location) 110 Frost Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Joseph F. Tiefenbraunn			4. DATE OF DEATH Month Day Year Jan. 8, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1884	9. AGE (In years last birthday) 74	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Druggist	10b. KIND OF BUSINESS OR INDUSTRY Drug	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Henry Tiefenbrunn	13b. MOTHER'S MAIDEN NAME Josephine Shoppe	14. NAME OF HUSBAND OR WIFE Rose Diebold Tiefenbrunn
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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. 155-10-2473A	17. INFORMANT Mrs. Rose Tiefenbrunn, Ferguson, Mo.
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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>Medullary Paralysis & DYSPHAGIA</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Embolism</u>	<u>1 year</u>
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DUE TO (c) <u>Advanced Arteriosclerosis</u>	<u>5-8 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>	<u>332 X</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

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
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21. I attended the deceased from <u>Feb 21 1956</u> to <u>Jan 6 1959</u> and last saw ^{her} him alive on <u>Jan 6 1959</u> Death occurred at <u>12 15 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>David Light DO</u>	(Degree or title)	22b. ADDRESS <u>5738 W. Florence</u>	22c. DATE SIGNED <u>1/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-10-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) Normandy, Mo.
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24. FUNERAL DIRECTOR White-Kullen Mortuary, Ferguson, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 1-9-59	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Lawrence F. Kibbe*
Licensed Embalmer No. *4596*
P. O. Address *Florent, Mo*

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.