

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023455

FILED JUN 18 1959

STATE FILE NUMBER
25428

Registration District No. Primary Registration District No.

Registration No. 5428

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, give TOWNSHIP only) OR TOWN St. Louis,		c. CITY OR TOWN ANY COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 1040 a N. Taylor Ave.	
Length of stay in 10-Days.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle Last Tennell.			4. DATE OF DEATH Month June Day 5 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 18 1890		9. AGE (In years, months, days) 68 9 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI	

13a. FATHER'S NAME William TENNELL		13b. MOTHER'S MAIDEN NAME Cora ?		14. NAME OF HUSBAND OR WIFE MAUD TENNELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BORNICE SANIFORD Address 4226 W. Bell	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FIBROSARCOMA OF LEFT THIGH WITH DUE TO (b) METASTASIS TO LUNGS, LIVER AND DUE TO (c) BONE Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6+ months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 197.3					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 **May 26, 1959** to **June 5, 1959** and last saw her alive on **June 5, 1959**.
Death occurred at **11, oop.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George M. Franke, M.D.		22b. ADDRESS 5600 Arsenal		22c. DATE SIGNED 6/6/59	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-11-59		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD		23d. LOCATION (City, town, or county) (State) 6500 St. Louis Ave MO	
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24. FUNERAL DIRECTOR ADDRESS A.F. WALTON 2707 Stoddard		25. DATE RECD. BY LOCAL REG. JUN 8 '59		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *H. Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *1123 N. J.*

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.