

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042606

FILED VS. NOV 19 1959

210264

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>6116a Bartmer</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Teckenbrock</b> Last <b>Teckenbrock</b>			4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/4/93</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	11. BIRTHPLACE (City and state or country) <b>Litchfield, Ky.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Patrick Maloney</b>	
13b. MOTHER'S MAIDEN NAME <b>Florence St. Clair</b>		14. NAME OF HUSBAND OR WIFE <b>Michael J. Teckenbrock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>497-16-1551</b>	
17. INFORMANT <b>Mrs. Edna Halterman, 2854 Endicott</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>332x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 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	
21. I attended the deceased from <b>11-5-59</b> to <b>11-7-59</b> and last saw her <b>her</b> alive on <b>11-7-59</b> Death occurred at <b>8:45A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Edward M. [Signature]</i>		22b. ADDRESS <b>1515 Lafayette Ave.</b>	
22c. DATE SIGNED <b>11-7-59</b>		22d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>11/9/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 9 1959</b>	
26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Warren A. Carver

Licensed Embalmer No. 3534

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.