

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38533

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

Township.....

Primary Registration District No.....

City **St Louis** No. **3941** **Pennsylvania** St. Ward)

File No.....

Registered No. **10928**

2. FULL NAME

(a) Residence. No. **3941 Penn'a. av. St. B4** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **50** yrs. - mos. - ds. How long in U.S., if of foreign birth? **5** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Christ Beckmann**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 10 1861**

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
	67	10	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **House work**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Germany**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Dr. Schmuelles**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mahelmina Bartus**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **Christian Beckmann**
(Address) **3941 Pennsylvania**

15. FILED **NOV - 3 1929** **Max C. Stanley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **November 7 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Aug 1928** to **Nov 7 1929** that I last saw him alive on **Nov 7 1929** and the death occurred, on the date stated above, at **4:15 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypertension
Hypertensive Heart Disease
Hemorrhage into lung
non Tubercular cause unknown

18. WHERE WAS DISEASE CONTRACTED **at place of Death**
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **No** DATE OF
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS? **Phys exam**
(Signed) **C. M. Stroud**, M. D.
Nov 7, 1929 (Address) **3701 Westminster**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Lakewood Park** DATE OF BURIAL **11-9-29**

20. UNDERTAKER **W. Schumacher** ADDRESS **3013 Insurance**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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