

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

Do not use this space.

3311

2740

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City St. Louis Mo. (No. \_\_\_\_\_)

Registration District No. 791  
Primary Registration District No. 1008  
City City Hospital

File No. \_\_\_\_\_  
Registered No. 809  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John Beasley  
(a) Residence No. 26 32 Duane St. Ward 21  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 7 yrs. - 0 mos. - 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Separated</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lara Beasley</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>8-14-1887</u>				
7. AGE	YEARS <u>42</u>	MONTHS <u>5</u>	DAYS <u>8</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Labourer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Hod-Carrier</u> (c) Name of employer _____				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-22-1930

17. I HEREBY CERTIFY, That I attended deceased from 1/20 1930 to 1/22 1930 that I last saw him alive on 1-22 1930, and that death occurred, on the date stated above, at 4:40 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral Hemorrhage  
82A (duration) yrs. mos. 2 ds.  
CONTRIBUTORY (SECONDARY) 7401 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? NO  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) Dr. E. Hale, M. D.  
1/22, 19/30 (Address) City Hospital

\*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.

9. BIRTHPLACE (CITY OR TOWN) Macon  
(STATE OR COUNTRY) Miss

10. NAME OF FATHER Jim Beasley

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

12. MAIDEN NAME OF MOTHER Bettie Black

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

14. INFORMANT A. Gertrude Creath  
(Address) City Hospital

15. FILED 114 25 1930 19 Max C. Farley REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood Cem DATE OF BURIAL 1-25-1930

20. UNDERTAKER Peoples Ind. Co. ADDRESS 3100 Franklin

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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