

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **0053**
St. **St Louis Ave**

File No. **14801**
Registered No. **4211**
St. Ward)

2. FULL NAME

(a) Residence No. **5652 St Louis St**, **6** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 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 **Catherine Beck**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 16 1859**

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs.	or min.
70	10	10		

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

10. NAME OF FATHER **John Beck**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **Catherine Party**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT (Address) **Catherine Beck 5652 St Louis**

15. FILED **with 27** 19 **1930** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 26 1930**

17. I HEREBY CERTIFY, That I attended deceased from **April 19**, 19**30**, to **April 25**, 19**30**, that I last saw him alive on **April 25**, 19**30**, and that death occurred, on the date stated above, at **12:30 am**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Internal Gastric Hemorrhage
General Emaciation
117A
118C (duration) **10 yrs** mos. ds.

CONTRIBUTORY (SECONDARY) **Gastric Ulcer's Chronic** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **117A**
IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS **Physical Examination**
(Signed) **John P. [Signature]**, M. D.
Apr 26 1930 (Address) **2330 1/2 Main Blvd**

*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 **Cemetery** DATE OF BURIAL **April 28 1930**
ADDRESS **5765 Delmar**

20. UNDERTAKER **Muller and Co**

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.

