

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

Do not use this space.

1. PLACE OF DEATH

County *St. Louis*

Registration District No. *1170*

Township *Central*

Primary Registration District No. *6248 H*

City *Richmond Mo*

(No. *St. Marys Hospital*)

File No. *3535*

Registered No. *16*

St. _____ Ward _____

2. FULL NAME

Myrtle Beasts

(a) Residence, No. *4555 Enright Ave* St. _____ 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 *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Divorced*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Otto Beasts*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 13, 1892*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
41 9 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Office Clerk*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Tamara Barr*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Windsor Illinois*

13. NAME *Charles E. Anderson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

15. MAIDEN NAME *Carrie M Force*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

17. INFORMANT *Carrie M. Anderson* (ADDRESS) *4555 Enright Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Valhalla Bur* DATE *Jan. 29 1934*

19. UNDERTAKER *Frীগkques Martini* (ADDRESS) *7228 St. Louis Highway*

20. FILED *Jan 26, 1934* *Terrebonne* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 26, 1934*

22. I HEREBY CERTIFY That I attended deceased from *Nov 31* to *Jan 24, 34*
I last saw him alive on *Jan 20, 1934* Death is said to have occurred on the date stated above, at *4:15* a.m.
The principal cause of death and related causes of importance were as follows:

Copious & obstructive pleural effusion
Other contributory causes of importance: *Ch. Nephritis, Hypertension*

Name of operating physician *Dr. J. J. Conroy* Date of operation _____
What test confirmed death? *Wax on Cornea* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify _____
(Signed) *James J. Conroy*
(Address) *7004 1/2 The Valley*

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.

