

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.

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

184
 Do not use this space.

REC'D FEB 10 1939

791
 1003

1. PLACE OF DEATH

(a) County 1 Registration District No.
 (b) Township Primary Registration District No.
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 260 Frances Becker

(a) Residence, No. 3450 Hereford st. 14 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
 4. COLOR OR RACE w hite
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Becker
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 9, 1886
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 0 26

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. hwk
 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) Illinois

FATHER
13. NAME William Becker

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

MOTHER
15. MAIDEN NAME Elizabeth Fletcher

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

17. INFORMANT Hosp. Info M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kurtis and Co. 2906 Gravois Ave

20. FILED JAN 5 1939 J. F. Brudick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/4/39 19

22. I HEREBY CERTIFY That I attended deceased from 12/27/38 to 1/4/39, 19
 I last saw her alive on 1/4/39, 19. Death is said to have occurred on the date stated above, at 3. p.
 The principal cause of death and related causes of importance were as follows:

Carcinoma
 c Metastasis
 Date of onset

Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? 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?
 If so, specify (Signed) John F. Flynn, M. D.
 (Address) City Hospital No. 1

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.....

Leo J. Budde....., Registered Apprentice No.....
working under my personal supervision.

Signed *Leo J. Budde*
Licensed/Embalmer No. *3989*
P. O. Address *St. Louis, Mo*

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 this body is not embalmed, above space should be left blank.