

AN 1 1939

FEB 7 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

3831
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
 (b) Township Carrollton Primary Registration District No. 200
 (c) City Capeville, Mo. (d) Street No. Capeville 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

(a) Residence, No. 210 Elizabeth Beck Capeville, Mo. St. (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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. Beck

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 30 - 1882

7. AGE YEARS 56 MONTHS 4 DAYS 28 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 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) Ill

13. NAME Henry Hoffa

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Mary Beres

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) Wm Beck
Capeville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Pauls Church DATE Feb 1 - 1939

19. FUNERAL DIRECTOR (ADDRESS) Beck
744 1/2 S. Main St. Capeville Mo

20. FILED JAN 31 1939 Local Registrar Wm Beck

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-28-1939

22. I HEREBY CERTIFY, That I attended deceased from 12-1-1938 to 1-28-1939

I last saw her alive on 1-25-1939. Death is said to have occurred on the date stated above, at 9 P. M.

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis

Date of onset

Other contributory causes of importance:

Chronic interstitial nephritis

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) W. D. Bennett, M. D.
 (Address) 606 Virginia Ave

WRITE PERMANENTLY, 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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STATEMENT BY LICENSED EMBALMER

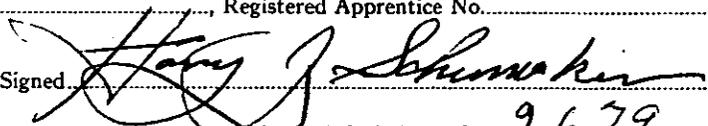
I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed  _____
Licensed Embalmer No. 2679

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.)