

S. No. 2
—11-10-39
v. 5-17-39
I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8791**
Registrar's No. **2274**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 Weeks.
(Specify whether
In this community 30 Years.
years, months or days)

3. (a) PRINT FULL NAME Francis P. Beard.
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Johann Beard. 6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased Feb. 15, 1910
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 0 22 hr. min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Deputy Sheriff.

11. Industry or business
12. Name Francis Beard.
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Kirk.
15. Birthplace Ireland.
(City, town, or county) (State or foreign country)

16. (a) Informant Jean Beard
(b) Address 5927 Hamilton

17. (a) Burial (b) Date thereof 3/9/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joseph M. Dineen
(b) Address 3840 Levee

19. (a) MAR 7 1940 (b) J. P. Beck
(If buried local) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County.....
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 5927 Hamilton Terrace.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ?..... years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 6th.
year 1940 hour 10. minute 20 A. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of the Left Iliac Vein and Lower Vena Cava with Multiple emboli of the legs of various ages
Due to Massive Pulmonary embolism with atelectasis of the left lower lobe of the lung
Other conditions followed as a result of
(Include pregnancy within 6 months of death)
Jan 17 1940 about 7:00 P.M.
of the 5400 Block of
Hamilton Ave
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 11/7/40

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work (Specify type of place) (e) Means of injury Fall

23. Signature Joseph M. Dineen (M. D. or other)
Address Deputy for Doc Beard

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.