

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33688

Registrar's No. 8385

Registration District No. 791

Primary Registration District No. _____

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: Deaconess Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day.
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Gustav Beyer.

3. (b) If veteran, name war No. 3. (c) Social Security No. None.

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Late Gertrude Beyer. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 24 1867.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 0 14 hr. min.

9. Birthplace Millwaukee, Wisconsin.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Insurance Agent.

11. Industry or business _____

12. Name Martin Beyer.

13. Birthplace Germany.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown.

15. Birthplace Unknown.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Parker

(b) Address 4142W Kossuth Ave.

17. (a) Burial (b) Date thereof 10-11-40.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine cem.

18. (a) Signature of funeral director H. Leidner and Co.

(b) Address 2223 St. Louis Ave.

19. (a) OCT 9 1940 (b) [Signature]
(Date received final report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County _____
(c) City or town Billings. NR
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8th
year 1940 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 10-7-40 to 10-8-40, 1940
that I last saw him alive on 10-8-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 days

Due to Hypertension 2 yrs.

Due to Prostatic Hypertrophy

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: [Signature]

Of operations [Signature]

Of autopsy [Signature]

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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work [Signature] (Specify type of place) (c) Means of injury [Signature]

23. Signature [Signature] (M. D. or other)

Address 3320 W. 40th Date signed 10-8-40

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

MOTHER FATHER

Pro loco.

In F. & Jacobin;
3320 St. Grand.

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St Louis

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, fact should be so stated above.