DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 16 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33869

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 8565

1. PLACE OF DEATH:

(a) County

(b) City or town St. louis, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Rock Hill Village (If outside city or town limits, write "RURAL") NR

(d) Street No. 819 N. Rock Hill Rd. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Charles Chenowith Beals

3. (b) If veteran, name war World War

3. (c) Social Security No. 494-03-5148

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Freda Deichler

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased June 11, 1891 (Month) (Day) (Year)

8. AGE: Years 49 | Months 4 | Days 4 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Mechanical Engineer

11. Industry or business A. Leschen & Sons

FATHER 12. Name Louis N. Beals

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

MOTHER 14. Maiden name Nellie E. House

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

16. (a) Informant's own signature Mrs. C. C. Beals

(b) Address 819 N. Rock Hill Rd.

17. (a) Valhalla (Burial, cremation, or removal) (b) Date thereof 10/18/40 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Robert Kenrick & Son

(b) Address Clayton Rd. at Concordia Lane

19. (a) OCT 16 1940 (Date received local registrar) (b) C. B. Bacheck (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15th year 1940 hour 7:30 minute P M.

21. I hereby certify that I attended the deceased from 10-3-, 1940, to 10-15, 1940 that I last saw him alive on 10-15-, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Infarction — Duration 7 days

Due to Malignant Hypertension

Due to

Other conditions — (Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy Posterior myocardial infarction

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Howard R. Bierman, M.D. (M. D. or other)

Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

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.....

Licensed Embalmer No. 1994

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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