

S. No. 2
4-13-40
7-5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40514

State File No. _____

791

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 10285

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: 4183 Enright Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4183 Enright Ave (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME: JAMES W. BEARD

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

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

6. (b) Name of husband or wife Augustine Beard 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased October 25 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>17</u>	hr. _____ min.

9. Birthplace Frankfort Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Mulvalhill Fur. Co.

MOTHER FATHER

12. Name James Beard

13. Birthplace Unknown
(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 Augustine Beard

(b) Address 4183 Enright ave

17. (a) Burial (b) Date thereof 12/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peters Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 3035 N. Union Ave

19. (a) DEC 14 1940 (b) J. D. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11 year 1940 hour 3 minutes 20 P M.

21. I hereby certify that I attended the deceased from October 11 1940 to Dec 11 1940 that I last saw him alive on Dec 11 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration 2 years

Due to Chronic Prostatitis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 12/1

Major findings: Of operations _____

Of autopsy _____

Duration

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 _____ (Specify type of place) (e) Means of injury _____

23. Signature S E Moore (M. D. or other) MD
Address 809 N. Jefferson Date signed 12/13/40

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

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 me

Chas. Gamm, Registered Apprentice No. 2349

working under my personal supervision.

Signed Chas. Gamm

Licensed Embalmer No. 2349

P. O. Address _____

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.