

No. 2  
-1-4-41  
5-17-39  
I X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 13 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 8274  
Registrar's No. 2442

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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 2-12-42 to 3-16-42  
(Specify whether  
In this community 1 month, 4 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State ILLINOIS (b) County Madison 999  
(c) City or town Glenn Crossing 11  
(If outside city or town limits, write "RURAL") NR  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country 21

3. (a) PRINT FULL NAME Mr. Albert Beran  
3. (b) If veteran, name was no  
3. (c) Social Security No. UNKNOWN

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 16  
year 1942 hour 7 minute 05 P.M.  
21. I hereby certify that I attended the deceased from 2-24  
1942 to 3-16 1942  
that I last saw him alive on 3-16 1942  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Agnes Beran  
6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased Jan. 6 1870  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration  
Cardiac failure & pulmonary edema 3 days  
Due to arteriosclerotic cardio-vascular disease  
arteriosclerotic encephalopathy 4 weeks  
Diabetes mellitus  
Other conditions Right thigh amputation, left  
(Include pregnancy within 3 months of death)  
Major findings: Hypertrophy of prostate with obstruction

8. AGE: Years Months Days If less than one day  
72 2 10 hr. min.

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Of autopsy 101

9. Birthplace Bahemia (City, town, or county) (State or foreign country)  
10. Usual occupation Coal Miner Retired

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name UNKNOWN  
13. Birthplace " " (City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace " " (City, town, or county) (State or foreign country)

16. (a) Informant Agnes Beran  
(b) Address Glenn Crossing Ill  
17. (a) Edwardsville Ill (b) Date thereof Mar 19 42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bugh Road, Collinsville  
18. (a) Signature of funeral director J. J. Bradley  
(b) Address Collinsville Ill  
19. (a) APR 18 1942 (b) J. J. Bradley  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence 59  
(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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature J. J. Bradley (M. D. or Other)  
Address BARNES HOSPITAL Date signed \_\_\_\_\_

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

990

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

Signed

Ben H. Palladin

Licensed Embalmer No.

2430

P. O. Address

P. O. Box 211

**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.**