S. No. 2
1—9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1943

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 8075

Registrar's No. 3086

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. Luke's 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: 999

(a) State Illinois (b) County Rock Island

(c) City or town Moline
(If outside city or town limits, write "RURAL")

(d) Street No. 1326 25th St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dr. Hugh Atlee Beam

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Mayme Beam

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased July (Month) 15 (Day) 1882 (Year)

8. AGE: Years 60 Months 8 Days ~~18~~ 15 If less than one day hr. min.

9. Birthplace Dokata City (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Physician & Surgeon

11. Industry or business

FATHER
12. Name Wm. Beam
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harriet Stewart
15. Birthplace Madison County (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mayme Beam
(b) Address Moline, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/43 (Month) (Day) (Year)
(c) Place: burial or cremation Moline, Ill

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) MAR 31 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day ~~30~~ 30 year 1943 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3-17-43, 19..., to 3-31-, 1943 that I last saw him alive on 3-31-, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Edema	2 days
Shock	1 day
Due to Cerebral arteriosclerosis	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Marked arteriosclerosis of Cerebral Vessels.

Of autopsy None

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 Doris L. Woolsey (M. D. or other) M.D.

Address 4957 Maryland Date signed 3-31-43

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoffman

Licensed Embalmer No. 2971

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.