

S. No. 2
DOM-2-43
5-17-39
X35897

19404

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED JUL 18 1943 18

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 6115

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:
De Paul Hospital.
(If not in hospital or institution, write street number or location)

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

In this community Lifetime
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William N. Besch

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 single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased March 17, 1925
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

18 3 18 hr. _____ min.

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

10. Usual occupation High School

11. Industry or business _____

12. Name Mathew Besch

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

14. Maiden name Frances Mahler

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

16. (a) Informant Mathew Besch

(b) Address 1427 a Union Blvd.,

17. (a) Burial (b) Date thereof 7-6-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Pk.

18. (a) Signature of funeral director Wacker-Heldner

(b) Address 3634 Harris Ave

19. (a) JUL 6 1943 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

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. 1427a Union Blvd.,
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 4th.
year 1943 hour 6:00 minute 8. M.

21. I hereby certify that I attended the deceased from Jan 10
1943, to July 3 1943;
that I last saw him alive on July 3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hodgkins disease Duration 1 yr.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Hodgkins disease

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 e. a. Stone (M. D. or other) _____
Address 3720 Washington Date signed 7-5-43

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

Signed..... *Robert Wheeler*
Licensed Embalmer No..... *2178*
P. O. Address..... *St. Louis, Mo.*

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.