

FILED MAY 20 1944
Registration District No. 3177

Primary Registration District No. 3063

Registrar's No. 1128

1. PLACE OF DEATH: **St. Louis**

(a) County **St. Louis**

(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Louis County 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 **Unknown**

3. (a) PRINT FULL NAME **Thomas E. Beatty**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male** (1) 5. Color or race **White**

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

6. (b) Name of husband or wife **Mona**

6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **July 17 1875**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	9	29	hr. _____ min. _____

9. Birthplace **Chicago Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Custodian**

11. Industry or business **Glenridge School, Clayton Mo**

12. Name **John Beatty**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mona Beatty**

(b) Address **5215 Vermont Ave.**

17. (a) **Burial** (b) Date thereof **May 18, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **Wacker Helderle**
3634 Gravois Ave.

(b) Address _____

19. (a) **MAY 18 1944** (b) **E. D. Mc Larran, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5215 Vermont Ave.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **15**
year **1944** hour **7** minute **15 A.** M.

21. I hereby certify that I attended the deceased from **May 6-44**
to **May 15-44**
that I last saw him alive on **May 14 44**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis**

Due to **Mitral Endocarditis**

Due to **Acute Rheumatic Fever**

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

Major findings:
Of operations _____
Of autopsy _____

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 **Roman Strong** (M. D. or other) **MD**
Address **4500 Virginia** Date signed **5-16-44**

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

1944

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 2645

P. O. Address St. Louis

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.