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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 13 1945**  
Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. 3283  
Registrar's No. 2893

Primary Registration District No. 3068

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Maplewood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7282 Gayola  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County 96  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL") 5  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 3  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Katherine C. Beins  
(b) If veteran, name war None  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 23  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from  
Nov. 15, 1944, to Jan. 23, 1945  
that I last saw her alive on Jan. 22, 1945  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Wm. Beins 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased April 27, 1874  
(Month) (Day) (Year)

Immediate cause of death  
Cerebral hemorrhage Duration 1 day  
Senility  
Ch. Myocarditis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
70 8 26 hr. \_\_\_\_\_ min.  
9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Christian Klaus  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Wilhemina Stroop  
15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Beins  
(b) Address 7292 Gayola Ave  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25, 1945  
(Month) (Day) (Year)  
(c) Place: burial or cremation Concordia Luthern Cem.  
18. (a) Signature of funeral director Jay B. Smith  
(b) Address 7456 Manchester Ave Maplewood  
19. (a) JAN 25 1945 (Date received local registrar)  
(b) E. S. McManus (Registrar's signature) Address 7266 Manchester Date signed 1-23-45

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 \_\_\_\_\_  
Signature J. Steiling (M. D. number) \_\_\_\_\_  
Address 7266 Manchester Date signed 1-23-45

*Dr. [unclear]*  
*3266*  
*1704*

**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 3454

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

Signed David C. Gilson

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

**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.