

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3970**
Registrar's No. **1017**

FILED FEB 16 1945

Registration District No. **318**

Primary Registration District No. **100**

Registrar's No. **1017**

1. PLACE OF DEATH:

(a) County **ST LOUIS**
(b) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSPITAL No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **BETTY BECKER**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **2**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **NOV 30 1870**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	1	29	_____ hr. _____ min.

9. Birthplace **ST CHARLES MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED**

11. Industry or business _____

MOTHER, FATHER {
12. Name **LOUIS BECKER**
13. Birthplace **ST CHARLES MO**
(City, town, or county) (State or foreign country)
14. Maiden name **ELVIRA CHARLES WORTH**
15. Birthplace **ST CHARLES MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS THOMPSON**
(b) Address **MUNNFORD TENN.**

17. (a) ~~Burial~~ **Removed** Date thereof **2-1-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAK GROVE CEM. ST. CHARLES MO.**

18. (a) Signature of funeral director **HACKMAN - BAUE FUNERAL**
(b) Address **HOME ST. CHARLES MO.**

19. (a) **FEB 1 1945** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____
(c) City or town **ST. GENEVIEVE**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN** day **29**
year **1945** hour **12** minute **45** P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Myocarditis
Chronic Interstitial Nephritis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) **1/31 a**

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)
(a) Means of injury **3**
23. Signature **Used** (M. D. or other) _____
Address _____ Date signed **2/1/45**

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.....

Ray E. Campbell

Licensed Embalmer No. *3881*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1067

1. PLACE OF DEATH:

(a) County.....
(b) City or town Jx Jours
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Betty Becker

3. (b) If veteran, name war.....

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

4. Sex J 5. Color or race w

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

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

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

7. Birth date of deceased Nov 30
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
74 1 1 1 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) MAR 1 1945 (b) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1945 hour 9 minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw h..... alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

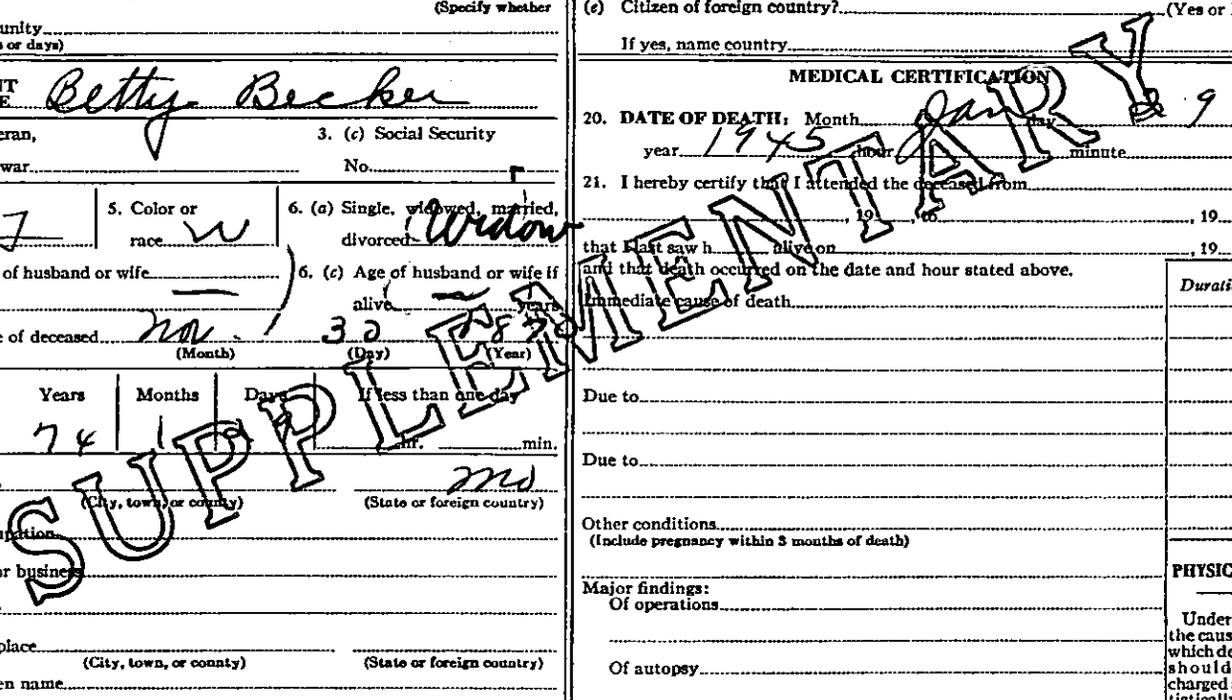
Major findings: Of operations.....
Of autopsy.....

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..... (M. D. or other).....
Address..... Date signed.....

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



3970