

No. 2
1-5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38423
Registrar's No. 2701

FILED DEC 1 1945

Registration District No. 377 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Manchester, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Manchester Nursing Home #
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 weeks
(Specify whether
In this community 78 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 020
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4946 Maffitt Pl. 9
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Henry Besselman
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Not mentioned
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 25, 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 8 29 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER {
12. Name Theodore Besselman
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Scholl
(b) Address 4946 Maffitt Pl.

17. (c) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) 11-29-45 (b) C. S. H. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23,
year 1945 hour 2:45 PM. minute _____ M.
21. I hereby certify that I attended the deceased from OCT 28
_____ 1945, to Nov. 23 1945;
that I last saw him alive on Nov 23 1945
and that death occurred on the date and hour stated above.

Immediate cause of death hepatic, chronic myocarditis, senile
Due to generalized arteriosclerosis
Due to 131

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 A. J. ... (M. D. or other) _____
Address 3507 ... Date signed 11-24-45

DECEASED INFORMATION SUPPLEMENTAL TO REGISTRATION

PHYSICIAN Underline the cause to which death should be charged statistically.

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 Gustav W Reutule

Licensed Embalmer No. 4329

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.

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

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:
 (a) County St Louis
 (b) City or town marquette
 (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)

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 _____

3. (a) PRINT FULL NAME John H. Besselman
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb 1945 year, 23 hour, _____ minute M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death CHRONIC NEPHRITIS

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb. 25 (Month) 25 (Day) _____ (Year)

Duration _____
 Physician _____
 Underline the cause to which death should be charged statistically.

8. AGE: Years 31 Months 8 Days _____ (If less than one day, hr. _____ min. _____)
 9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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)

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy 1312
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____ (Registrar's signature)
 (Date received local registrar) _____

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 G. J. Marklin M.D. (M. D. or other)
 Address 3507 P. TOMAL Date signed 12-4-45

38423