

FILED JAN 25 1946 318

Registration District No. _____

Primary Registration District No. _____

1003

State File No. _____

Registrar's No. _____

407

73

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
910 Russell Blvd. /
(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 OLIVER BECKMAN

3. (b) If veteran, name war World War #1 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased August 20 1891
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Upholsterer

11. Industry or business _____

12. Name August Beckman
Sweden

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

14. Maiden name Johanna

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

16. (a) Informant Minnie Beckman wife

(b) Address 910 Russell

17. (a) Burial (b) Date thereof 1/15/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Sullivan Bro's.

(b) Address 2849 N. Euclid Ave

19. (a) JAN 14 1946 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 910 Russell Blvd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

200
2/3
1/17
9
10

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12th
year 1946 hour 11 minute 30 a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Crown Arteriosclerosis

Due to Crown Arteriosclerosis

Due to 9/4/46

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 Samuel E. Taylor (M. D. or other)

Address _____ Date signed 1/15/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 L. Brinkman
Licensed Embalmer No. *3553*

P. O. Address.....

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.