

FILED MAY 27 1946

Registration District No. **3063**

Primary Registration District No. **3063**

Registrar's No. **1109**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Clayton**
(c) Name of hospital or institution: **St. Louis County Hospital**
(d) Length of stay: In hospital or institution **5 hrs. 40 min.**
In this community **60 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Sherman**
(d) Street No. **0**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **BELLE BEACH**

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 **Married**
6. (b) Name of husband or wife **Benjamin Beach**
6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **January 6 1879**

8. AGE: Years **67** Months **4** Days **18**
If less than one day _____ hr. _____ min.

9. Birthplace **Wayne County Kentucky**

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **John Grasham**
13. Birthplace **Unknown**
14. Maiden name **Minerva Edwards**
15. Birthplace **Unknown**

16. (a) Informant **Benjamin Beach - Husband**
(b) Address **Sherman, Mo.**

17. (a) **Burial** (b) Date thereof **May 22 1946**
(c) Place: burial or cremation **Sunset Funeral Park**

18. (a) Signature of funeral director **Dallwin, Mo.**
(b) Address _____

19. (a) **5-22-46** (b) **Ed Me Davron MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19th**
year **1946** hour **Six** minute **55** P.M.

21. I hereby certify that I attended the deceased from **May 19th 1946** to **May 19th 1946**
that I last saw **her** alive on **May 19th 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **1 day**

Due to **Hypertensive Vascular Disease** ?

Due to _____

Other conditions _____

Major findings: _____
Of operations _____
Of autopsy **as above**

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? _____
(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 **Paul B Datterott** (M. D. or other) **MD**
Address **St Louis Co Hosp** Date signed **5/20/46**

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed *Theo. Schradw*

..... Licensed Embalmer No. *3066*

..... P. O. Address *Dallwin, 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.