

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22013**

**FILED** JUL 31 1946  
318

Registrar's No. **5545**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri.**

(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**St. Louis City Hospital - Max C. Starkloff Memorial**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **25 years** (Specify whether years, months or days)

In this community **25 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **boo**

(c) City or town **St. Louis** **267**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1308 a N. Market St.**  
**Memorial** (If rural, give location)

(e) Citizen of foreign country? **9** (Yes or No) **8**

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **GRACE MEACHAM**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Beamon Meacham** 6. (c) Age of husband or wife if alive **9** years

7. Birth date of deceased **December 3rd, 1909**  
(Month) (Day) (Year)

8. AGE: Years **36** Months **6** Days **18** If less than one day hr. min.

9. Birthplace **Sligo Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **James W. Douglas** **9**

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

14. Maiden name **unknown**

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

16. (a) Informant **Mr. Beamon**

(b) Address **1308a N. Market St**

17. (a) **Burial** (b) Date thereof **6-24-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cem**

18. (a) Signature of funeral director **Henry Leidner**

(b) Address **2223 St. Louis Ave.**

19. (a) **JUN 23 1946** (b) **J. P. Breduch**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **21st**  
year **1946** hour **1:10** minute **A** M.

21. I hereby certify that I attended the deceased from **6/11/46**  
\_\_\_\_\_, 19\_\_\_\_, to **6/21/46**, 19\_\_\_\_;

that I last saw her **er** alive on **6/21/46**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

*Decomposition following bifurcal fracture of femur (6 deep) for malignant hypertension*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **9/4**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 **John Thomas** (M. D. or other) **8**  
Address **City Hospital** Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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

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**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 *John P. Beckholz*  
Licensed Embalmer No. *1674*  
P. O. Address *2223 St. Louis Ave*

**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.**