

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

42126

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED DEC 17 1946  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

Registrar's No. 10358

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: St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 94

(c) City or town Flat River (If outside city or town limits, write "RURAL") 5

(d) Street No. 115 Roosevelt (If rural, give location) NR 2

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No!)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SHANNON Kay BECKETT

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2  
year 1946 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-21 1946, to 12-2 1946;  
that I last saw her alive on 12-2 1946;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 11 21 46  
(Month) (Day) (Year)

Immediate cause of death Aspiration of Vomitus

Due to Myelomeningocele, lumbar region

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
11 hr. \_\_\_\_\_ min.

9. Birthplace Bonne Terre Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Nathan P. Beckett

13. Birthplace R. Wood Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Conley

15. Birthplace R. Wood Mo  
(City, town, or county) (State or foreign country)

Major findings: 157

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant M. Bernard

(b) Address 500 S. Kingshighway

17. (a) Removal (b) Date thereof 12-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director Nathan P. Beckett, (Pastor)

(b) Address Flat River, Mo

19. (c) DEC 1 1946 J. F. Beckett  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature R. J. Blotter (M. D. or other) \_\_\_\_\_  
Address 500 S. Kingshighway Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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

40935

10358

08/19/00

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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.....

Licensed Embalmer No.....

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.**