

No. 2
5-43
-17-39
X36671

FILED JAN 23 1947

Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **SIXSEVEN**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(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 **Missouri** (b) County **St. Louis 96**
(c) City or town **Lemay**
(If outside city or town limits, write "RURAL")
(d) Street No. **701 Hoffmeister**
(If rural, give location) **NR. 0**
(e) Citizen of foreign country? **no** (Yes or No) **/**
If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Beseda**

3. (b) If veteran, name war **no** 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 **Mary Beseda** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Sept 15 1894**
(Month) (Day) (Year)

8. AGE: Years **52** Months **3** Days **9** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Fireman**

11. Industry or business **Carday**

12. Name **Henry Beseda**

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

14. Maiden name **Julia ?**

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

16. (a) Informant **Mary Beseda**

(b) Address **701 Hoffmeister**

17. (a) **burial** (b) Date thereof **12-28-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Olive**

18. (a) Signature of funeral director **Fendler Und. Co.**

(b) Address **7420 Michigan Ave.**

19. (a) **DEC 26 1946** (b) **J. H. Rudisch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **24** year **1946** hour **4:20** 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 **Acute Alcoholism** Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **J H H**

Major findings: Of operations _____

Of autopsy _____

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

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 **3**

23. Signature **Patrick J. O'Connell** (M. D. or Dentist)

Date signed **1/2/47**

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.....

Licensed Embalmer No. *3077*

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.