S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10536

FILED APR 14 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3540

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. Anthony'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 Sept. 27, 1945
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County 6-Ab.

(c) City or town St. Louis, 1617
(If outside city or town limits, write "RURAL")

(d) Street No. St. Anthony Hospital, 3520 Chippewa 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Sister M. Macaria Beck Augusta

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 Religious

6. (b) Name of husband or wife

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

7. Birth date of deceased August 18, 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 13 If less than one day hr. min.

9. Birthplace Tondern, Schleswig Germany Holstein 4
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Joseph Beck 4
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna M. Hansen 4
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Sister at St. Anthony Hospt.
(b) Address 3520 Chippewa St. St. Louis

17. (a) Burial, (b) Date thereof 4/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul Cem.

18. (a) Signature of funeral director Gebken-Benz Mortuary
(b) Address 2842 Meramec St.,

19. (a) APR 3 1947 (b) J. F. Breneck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~March~~ April day 1
year 1947 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from March 15, 1947 to April 1, 1947
that I last saw her alive on March 31, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to arterio-sclerosis	1 yrs
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) MD

Address 3318 S. Grand Date signed 4-1-47

(Licensed Embalmer's Statement on Reverse Side)

3540

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 me

, Registered Apprentice No. ,

working under my personal supervision.

Signed Joe S. Benz

Licensed Embalmer No. 04249

P. O. Address 2842 Meramec St., St. Louis, 18, 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.