No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY,
National Office of Vital Statistics

FILED MAY 14 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14845

Primary Registration District No. 1003

Registrar's No. 4703

1. PLACE OF DEATH:

(a) County

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

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

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1105 So. 7th St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME RUDOLPH BEIER

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased October (Month) 6 (Day) 1876 (Year)

8. AGE: Years 70 Months 7 Days 3 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant Henry W. Gockel

(b) Address 1105 So. 7th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-47 (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 9 1947 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th year 1947 hour 4:38 minute A.M.

21. I hereby certify that I attended the deceased from 4-28-47, 19..., to 5-9-47, 19...; that I last saw him alive on 5-9-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac decompensation	
Due to: Arteriosclerotic & hypertensive heart disease	
Due to: with auricular fibrillation	
Other conditions (Include pregnancy within 3 months of death): Psychosis with cerebral arteriosclerosis	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other) M.D.

Address 1515 Lafayette Date signed 5-9-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 3575

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.