

National Office of Vital Statistics
FILED SEP 23 1947

Registration District No. **2377**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Koch (rural)**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Robert Koch Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **419 days**
(Specify whether
In this community **3 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2410 N. Taylor**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Donnell Beard**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sarah Nell Lacy Beard** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **November 8 1916**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	30	9	6hr.min.

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

10. Usual occupation **mechanic**

11. Industry or business

12. Name **Fred Beard**

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

14. Maiden name **Ular Hager**

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

16. (a) Informant **Hospital Records**

(b) Address **Robert Koch Hospital**

17. (a) **SHIPPING** (b) Date thereof **8-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Humboldt Tenn.**

18. (a) Signature of funeral director **ATKINS Bros**

(b) Address **3644 Frimery Ave**

19. (a) **8-16-47** (b) **Beulah Hager**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **14**
year **1947** hour **8** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **6-21** 19**46** to **8-14** 19**47**
that I last saw him alive on **8-14** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Due to **136**
Due to

Other conditions (Include pregnancy within 3 months of death)

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? (Specify type of place)

While at work (Specify type of place) (e) Means of injury
23. Signature **William A. Hauer** (M. D. or other) **MD**
Address **Robert Koch Hospital** Date signed **8-14-47**

Duration **20 hrs?**
PHYSICIAN
Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING 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

Louis V. Atkins

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney av*

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.