

No. 2  
4-1/47  
5-17-39

FILED NOV 14 1947  
318  
Registration District No. 318

Primary Registration District No. 1003

State File No. 10193  
Registrar's No. 10193

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

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: **City Hospital** *0*  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
**St. Louis** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** *oad*  
 (b) County.....  
 (c) City or town..... **St. Louis** *17*  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **2617a Rauschenbach Ave.** *9*  
**20** (If rural, give location)  
 (e) Citizen of foreign country?..... *0* (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME..... **IRENE BECKER**

3. (b) If veteran, name war..... **none**

3. (c) Social Security No. .... **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **Nov.** day..... **1st**  
 year..... **1947** hour..... **7:45** minute..... **P** M.  
 21. I hereby certify that I attended the deceased from..... **10/25/47**  
 ....., 19....., to..... **Nov. 1st** 19**47**.  
 that I last saw **her** alive on..... **Nov. 1st** 19**47**.  
 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..... **single** *0*

6. (b) Name of husband or wife.....

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

7. Birth date of deceased..... **August 11th, 1893**  
(Month) (Day) (Year)

Immediate cause of death.....  
**Serous cystadenoma of ovary & metastases of extension to surrounding tissues.**  
**Hydrothorax, pt. & hydrocephalus, pt.**

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations..... **H.A.**

Of autopsy.....

PHYSICIAN.....

Underline the cause of which death should be charged statistically.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<b>54</b>	<b>2</b>	<b>20</b>	hr. min.

9. Birthplace..... **St. Louis Mo.** *0*  
(City, town, or county) (State or foreign country)

10. Usual occupation..... **none**

11. Industry or business.....

12. Name..... **George Becker** *1*

13. Birthplace..... **New York** *1*  
(City, town, or county) (State or foreign country)

14. Maiden name..... **Elizabeth Helbig** *1*

15. Birthplace..... **Red Bud Ill** *1*  
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Robert H. Grone**

(b) Address..... **234 Glen Roadm Webster Grove**

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

(c) Place: burial or cremation..... **Calvary Cemetery**

18. (a) Signature of funeral director..... **Hy. Leidner U. Co.**  
 (b) Address..... **2223 St. Louis Ave.**

19. (a) **NOV 4 1947** (b) **J. F. Buednick** *1*  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... **no**  
 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?..... *0*  
(Specify type of place)

While at work..... Means of injury.....

23. Signature..... **Earl P. Simon** *1* (M. D. or other)  
 Address..... **1515 Lafayette** Date signed..... **11/3/47**

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

*Rex Campbell*

Licensed Embalmer No.

*3881*

P. O. Address

*2127 St. Louis Ave*

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.

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**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:  
(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

**3. (a) PRINT FULL NAME** Irene Becker

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

**8. AGE:** Years 54 Months 2 Days 11 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

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

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

**MOTHER FATHER**

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 11-4-47 (b) Nov 7 1947  
(Date received local registrar) (Registrar's file number)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

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

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-35494