

No. 300  
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Miss Dabb  
Dr. Huber Clinic Building City Ho  
10-376  
MISSOURI  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 6 1949

State File No. **39578**  
**04525**  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, write RURAL and give township) <b>Richmond Heights</b>		c. LENGTH OF STAY (in this place) <b>15</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		d. STREET ADDRESS (If rural, give location) <b>5541 Grace Ave</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>									
3. NAME OF DECEASED (Type or Print) <b>Louise Begeman</b>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>11-27-1949</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>December 31 1871</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>****</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Ernest Begeman</b>			13b. MOTHER'S MAIDEN NAME <b>Begeman</b>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Norman Begeman</b>				ADDRESS <b>Hills Drive Kirkwood</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lobar pneumonia, lower lobe, (bilateral)</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						490X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>490X</b>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>Feb. 9, 1949, to Nov. 27, 1949</b> , that I last saw the deceased alive on <b>Nov. 26, 1949</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>(Melvin J. Huber D. M.D.)</b>				23b. ADDRESS <b>634 N. Grand Blvd.</b>		23c. DATE SIGNED <b>11-28-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>11-28-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>3211 Sublette Ave Mo</b>				
DATE REC'D BY LOCAL REG. <b>11-28-49</b>		REGISTRAR'S SIGNATURE <b>Berbert Kwonke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Ziegenhain Bros.</b>		ADDRESS <b>6409 Gravois Ave</b>			

**STATEMENT BY LICENSING MEMBER**

I hereby certify that the following information is recorded in the records of the State of Illinois as a result of my personal or professional knowledge.

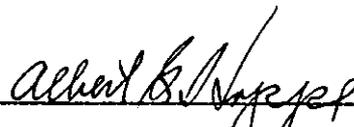
State of Illinois

working in my personal or professional capacity.

Signature

State of Illinois

Signed



Licensing Member No. 2971

P.O. Address

Note: The above information is provided by the member in his or her own knowledge and belief. (Failure to comply with the above constitutes grounds for revocation of license.)

If this is not a true and correct statement, the member shall be considered liable.