

FILED DEC 27 1949

82715-49

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42267

10674

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 18 hrs.			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 141 Reading road			
3. NAME OF DECEASED (Type or Print) a. (First) Infant		b. (Middle) Bean		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Dec. 11, 1949		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Dec. 10th, 1919	
9. AGE (In years last birthday) 0		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 18 HRS. Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Monroe Bean			
13b. MOTHER'S MAIDEN NAME Betty Olsen		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Monroe Bean 141 Reading Ave. Maryland Heights, Mo.	
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) <u>PREMATURITY</u> ANTECEDENT CAUSES Morbidity 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. <u>HEPHEPISIS</u>			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) 1949	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12:00 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 71328	
22. I hereby certify that I attended the deceased from _____ 19____, to _____ 12-10, 1944, that I last saw the deceased alive on _____ 19____, and that death occurred at _____ 3156A, from the causes and on the date stated above.					
23a. SIGNATURE A. Q. Johnson		23b. ADDRESS (Degree or title) 337 W. Kirkwood		23c. DATE SIGNED 12-12-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/12/49		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jay B. Smith 7430 Manchester Rd. Maplewood, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Not Embalmed* _____

Licensed Embalmer No. _____

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.