

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4-19869**  
**2311**

FILED MAR 30 1951

|   |                            |   |  |   |  |   |  |
|---|----------------------------|---|--|---|--|---|--|
| BIRTH NO. _____   |                            | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1000</b>  |  | Registrar's No. _____                           |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                            |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b><br>b. COUNTY <b>St. Louis</b> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |                            | c. LENGTH OF STAY (in this place) <b>10-days</b>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richmond Heights</b>  |  | <b>4535</b>                                     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Alexian Bros. Hospital</b>   |                            |   |  | d. STREET ADDRESS (If rural, give location) <b>2 035 Bellevue Ave.</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Joseph</b><br>b. (Middle) <b>W.</b><br>c. (Last) <b>Becker</b>  |                            |   | 4. DATE OF DEATH (Month/Day/Year) <b>Mar. 10, 1950</b>     |   |  |   |  |
| 5. SEX <b>M.</b>  | 6. COLOR OR RACE <b>W.</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>W. L.</b>   |  | 8. DATE OF BIRTH <b>June 12, 1882</b>   | 9. AGE (In years last birthday) <b>68</b>  | 10. UNDER 1 YEAR Months <b>8</b> Days <b>28</b> | 11. UNDER 1 HR. Hours <b></b> Min. <b></b>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Salesman</b>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  | 11. BIRTHPLACE (State or foreign country) <b>Iowa</b>   |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>         |  |
| 13a. FATHER'S NAME <b>Joseph Becker</b>   |                            |   | 13b. MOTHER'S MAIDEN NAME <b>Unknown</b>                   |   | 14. NAME OF HUSBAND OR WIFE <b>Mrs. Mabel Becker</b>                             |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <b>no</b>  |                            |   | 16. SOCIAL SECURITY NO. <b>498-01-8997</b>                 | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mr. Charles W. Becker, 4516 Lindell Blvd.</b>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b) and (c)<br><b>Fracture of hip Traumatic</b>  |                            | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Fracture of hip Traumatic</b>  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |                            | ANTECEDENT CAUSES<br>Morbidity condition, if any, giving rise to the above cause (c) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Pneumonia</b>  |                            |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>3/5/51</b>  |                            | 19b. MAJOR FINDINGS OF OPERATION <b>Fracture of hip Traumatic</b>   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |                            | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>3-2-51</b>   |                            | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? <b>Fell in home</b>  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>3/2</b> , 1951, to <b>3/10</b> , 1951, that I last saw the deceased alive on <b>3/10</b> , 1951, and that death occurred at <b>5:25 PM</b> , from the causes and on the date stated above. <b>2</b> |                            |   |  |   |  |   |  |
| 23a. SIGNATURE <b>Chas. C. Schopp M.D.</b> (Degree or title)  |                            |   |  | 23b. ADDRESS <b>505 Humboldt Bldg.</b>  |  | 23c. DATE SIGNED <b>3/12/51</b>                 |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                            | 24b. DATE <b>3-14-51</b>  | 24c. NAME OF CEMETERY OR CREMATORY <b>Galvary Cemetery</b> |   | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>              |   |  |
| DATE RECORDED BY LOCAL REG. <b>12</b>   |                            | REGISTRAR'S SIGNATURE <b>J. B. Foster</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Donnelly</b>  |  | ADDRESS <b>3840 Lindell Blvd.</b>               |  |

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

MAR 12 1951

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

*W H VanMatre*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.