

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33622**

FILED OCT 11 1952

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2196**

1. PLACE OF DEATH
 a. COUNTY **ST LOUIS**
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **CLAYTON**
 c. LENGTH OF STAY (In this place) **D.O.H.**
 d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **ST LOUIS CO HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE **Missouri** b. COUNTY **ST LOUIS**
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **OVERLAND 423A**
 d. STREET ADDRESS (If rural, give location) **9311 MIDLAND**

3. NAME OF DECEASED (Type or Print)
 a. (First) **OTTO** b. (Middle) _____ c. (Last) **BEESE**
4. DATE OF DEATH (Month) (Day) (Year) **Sept. 26, 1952**

5. SEX **MALE** **6. COLOR OR RACE** **White**
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **SINGLE**
8. DATE OF BIRTH **JULY 19 1873**
9. AGE (In years) (Month) (Day) (Year) **79**
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **ODD JOBS**
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) **ALTON ILLINOIS**
12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **CARL BEESE** **13b. MOTHER'S MAIDEN NAME** **UNKNOWN**
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. **UNKNOWN**
17. INFORMANT'S SIGNATURE OR NAME **JUDITH BEESE** **ADDRESS** **9209 DEERPHING**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **unknown natural causes**
ANTECEDENT CAUSES (b) **7955**
 *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
2. OTHER SIGNIFICANT CONDITIONS: (c) **Conditions contributing to the death but not related to the disease or condition causing death.**

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION:** _____ **20. AUTOPSY?** YES NO

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) _____ **21e. INJURY OCCURRED WHILE AT WORK** **NOT WHILE AT WORK** **21f. HOW DID INJURY OCCUR?** _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE **Herbert R. Donke** (Degree or title) _____ **23b. ADDRESS** **651 S. Brentwood Blvd.** **23c. DATE SIGNED** **10/3/52**
Herbert R. Donke M.D. Local Registrar

24a. BURIAL, CREMATION, REMOVAL (Specify) **SEP 29-52** **24b. DATE** _____ **24c. NAME OF ZEMETERY OR CREMATORY** **ALTON ILL (CITY ZEMETERY)** **24d. LOCATION** (City, town, or county) (State) **ALTON ILLINOIS**

DATE REC'D BY LOCAL REG. **9-28-52** **REGISTRAR'S SIGNATURE** **Herbert R. Donke** **25. FUNERAL DIRECTOR'S SIGNATURE** **EARL PHILIPMAN** **ADDRESS** **OVERLAND MO**

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

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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

Earl K. Hellemann

Licensed Embalmer No. *3501*

P. O. Address *Overland Missouri*

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.