

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41624

State File No. ....

FILED NOV. 25 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2934

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY _____ |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Normandy, Missouri</u> |  | c. CITY OR TOWN <u>St. Louis</u>   | d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>4 1/2 yrs</u>   |  | e. STREET ADDRESS (If rural, give location) <u>4488 Penrose St.</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Sullivan Nursing Home.</u>                                |  |  |   |

|  |                             |                           |   |
|--|-----------------------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Ann</u> | b. (Middle) <u>Jeanette</u> | c. (Last) <u>Beckerle</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>November 11, 1953</u> |
|--|-----------------------------|---------------------------|---|

|  |                               |   |  |   |   |   |
|--|-------------------------------|---|--|---|---|---|
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>October 10, 1896</u> | 9. AGE (In years last birthday) <u>57</u>                   | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home -</u>                    |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>9</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |

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| 13a. FATHER'S NAME <u>Parker C. Thompson</u> | 13b. MOTHER'S MAIDEN NAME <u>Fannie M. Kitterman</u> | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> |
|--|--|---|

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|---|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Robert Thompson 4488 Penrose St.</u> |
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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |                              | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>   |                              | <u>2 wks.</u>                    |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertensive Cardiovascular disease</u><br>DUE TO (c) <u>Diabetes mellitus</u> |                              | <u>unknown</u>                   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Old hemiplegia</u>  |   | <u>unknown over 10 years</u> |                                  |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

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|---|--|---|
| 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) <u>260X</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 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 Aug 26, 1949, to Nov 11, 1953, that I last saw the deceased alive on Nov 9, 1953, and that death occurred at 7:50 a m., from the causes and on the date stated above.

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|---|--|----------------------------------|
| 23a. SIGNATURE <u>Lewis Littmann MD</u> (Degree or title) | 23b. ADDRESS <u>8231 Clayton Rd (17)</u> | 23c. DATE SIGNED <u>11/13/53</u> |
|---|--|----------------------------------|

|   |                           |   |  |
|---|---------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11/14/53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u> |
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| DATE REC'D BY LOCAL REG. <u>11-13-53</u> | REGISTRAR'S SIGNATURE <u>Hubert R. Dombke M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Handwritten:* 4

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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.....  
Signature of Student Embalmer

Signed *Reginald G. Burnley*.....

Licensed Embalmer No. *4902*.....

P. O. Address *St. Louis, Mo.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.