

FILED NOV 23 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41765

BIRTH NO. _____ REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 4469 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Ste. Genevieve		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE Missouri b. COUNTY Ste. Genevieve	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ste. Genevieve		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ste. Genevieve 0951 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 199 North 5th		d. STREET ADDRESS (If rural, give location) 199 North 5th	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) WILLIAM	b. (Middle) HENRY	c. (Last) BECKERMAN	(Month) Nov	(Day) 17	(Year) 1953
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov July 3, 1881		9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - laborer		10b. KIND OF BUSINESS OR INDUSTRY Lime Co	11. BIRTHPLACE (City and State or Foreign Country) Ste. Genevieve, Mo 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George Beckerman	13b. MOTHER'S MAIDEN NAME Mary Hauck	14. NAME OF HUSBAND OR WIFE Libbie Mentier
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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. 492-03-4760	17. INFORMANT'S SIGNATURE OR NAME Mr. Ralph R. Beckerman	ADDRESS Ste. Genevieve,
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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, asphyxia, 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) Cerebral arteriosclerosis		
	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. Chronic myocarditis		2 years.	

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 1, 1950, to Nov. 17, 1953, that I last saw the deceased alive on Nov. 17, 1953, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE R. L. Lanning, M.D.	(Degree or title)	23b. ADDRESS Ste. Genevieve Mo	23c. DATE SIGNED 11/18/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 20, 1953	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) Ste. Genevieve, Mo
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DATE REC'D BY LOCAL REG. Nov. 19, 1953	REGISTRAR'S SIGNATURE Lucille Barber	25. FUNERAL DIRECTOR'S SIGNATURE James J. Sauls	ADDRESS Ste. Genevieve, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC -

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 *James H. Staulo*
Licensed Embalmer No. 3817

P. O. Address Ste. Genevieve, 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 this body is not embalmed, fact should be so stated above.