

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30576**
8682

FILED OCT 7 - 1955

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY St. Louis, Mo.				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 1215 Shawmut Place				205/10		
3. NAME OF DECEASED (Type or Print) a. (First) Geraldine			b. (Middle) Jeanice			c. (Last) Beard			4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1955	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 10/23/1913		9. AGE (In years last birthday) 41		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXXXX		11. BIRTHPLACE (City and State or Foreign Country) East St. Louis, Ill.			12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Hugh Little			13b. MOTHER'S MAIDEN NAME Annie Loveless			14. NAME OF HUSBAND OR WIFE James Beard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 058 12 0921		17. INFORMANT'S SIGNATURE OR NAME Annie Little			ADDRESS 1215 Shawmut Place			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Stem Tumor (?glioma)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
*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								
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.								
		DUE TO (b) _____								
		DUE TO (c) _____								
18. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION P 937x						20. AUTOPSY? YES <input checked="" 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) _____		
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. 22, 1955 , to Sept. 30, 1955 , that I last saw the deceased alive on Sept. 30, 1955 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above.										
23a. SIGNATURE C. J. McMillin, M.D.				23b. ADDRESS BARNES HOSPITAL				23c. DATE SIGNED 10/1/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/7/55		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.,				
DATE REC'D BY LOCAL REG. OCT 5 1955		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Garberry		ADDRESS 1202 Finney Ave.			

m.j.B. (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.....
Signature of Student Embalmer

Signed *Melvin E. Green*.....

Licensed Embalmer No. *442*.....

P. O. Address *St. Louis*.....

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.