

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

05245

FILED NOV 16 1956
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STATE FILE NUMBER

9675

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.			Length of stay in lb	d. STREET ADDRESS 324 SO. JEFFERSON	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> BEARD			4. DATE OF DEATH Month Day Year SEPT. 28, 1956		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/56	9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months Days Hours 0 2 3 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GOVAN BEARD			14. MOTHER'S MAIDEN NAME MAYOLA DIXON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address ST. LOUIS CITY HOSPITAL RECORDS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - non viable fetus DUE TO (b) Premature Delivery DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION 776x COUNTY STATE		
21. I attended the deceased from 9/25/56 to 9/28/56 and last saw her alive on 9/28/56 Death occurred at 3:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE W. B. Avery M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 9/28/56
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-31-56	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.			25. DATE RECD. BY LOCAL REG. OCT 24 1956		26. REGISTRAR'S SIGNATURE J. Carl Smith MD m88

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.