

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED-MAR 18 1957

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State File No. 9897  
Registrar's No. 2041

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3/ St. Louis State Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>21290 5560 Pershing Avenue</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frances</b>			b. (Middle) _____			c. (Last) <b>Beale</b>			
4. DATE OF DEATH (Month) (Day) (Year) <b>February 27, 1957</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>September 15, 1884</b>			
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____		IF UNDER 11 HRS. Hours _____		IF UNDER 15 MIN. Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>									
13a. FATHER'S NAME <b>John Dickerson</b>			13b. MOTHER'S MAIDEN NAME <b>Jennie</b>			14. NAME OF HUSBAND OR WIFE <b>Thomas F. Beale</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Leone S. Robinson 525 Hamilton</b>					
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) <b>Ventricular fibrillation</b>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____				<b>2 weeks</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Psychosis with Cerebral arteriosclerosis</b>				<b>433.1</b>				<b>10 years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 <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 <b>3-29</b> , 19 <b>48</b> to <b>2-27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-27</b> , 1957, and that death occurred at <b>6:00a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>H. K. Beale, M.D.</b>				23b. ADDRESS <b>5400 Arsenal Street</b>		23c. DATE SIGNED <b>2-27-57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2-28-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City</b>		24d. LOCATION (City, town, or county) (State) <b>Fayette Mo</b>			
DATE REC'D BY LOCAL REG. <b>FEB 28 '57</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington</b>					

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

