

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11605

STATE FILE NUMBER

FILED APR 8 - 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 828

Health, Welfare
Public
Service

300
156

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

7809 Olivette

1. PLACE OF DEATH a. COUNTY <u>St. Louis 4000</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Olivette</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Olivette 4380</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1010 N. Price</u> Length of stay in 1b <u>years</u>		d. STREET ADDRESS (If outside, give location) <u>1010 N. Price</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>C.</u> Last <u>Beckmann</u>			4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>57</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/77</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John G. Beckmann</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Meuser</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>493-01-5155</u>		17. INFORMANT <u>Marie Beckmann Olivette, Mo.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic coma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Hepatic Insufficiency</u> DUE TO (c) <u>Chronic portal cirrhosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>Days</u> <u>Months</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9-9-56</u> to <u>3-27-57</u> and last saw <u>him</u> alive on <u>3-26-57</u> Death occurred at <u>8:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert E. Owen D.O.</u> (Degree or title)		22b. ADDRESS <u>7805 Olive Blvd. St. Louis 24 Mo</u>	
22c. DATE SIGNED <u>3-27-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>3/30/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Ortmann F Home-Overland, Missouri</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3/27/57</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert A. Donkha MD</u>		89	

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 *Al C Ostmann*
Licensed Embalmer No. **3478**

P. O. Address

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.