

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26655

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6882

300
1-56

All 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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP.</u>		Length of stay in lb <u>2 1/2 wks</u>	
d. STREET ADDRESS <u>7123 ST. JAMES ST</u>		(If outside, give location) <u>St. Louis Mo</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>—</u> Last <u>VAN BEERS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1882</u>
9. AGE (In years last birthday) <u>74</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>RET. LABOER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	11. BIRTHPLACE (City and state or country) <u>BELGIUM</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>UNKNOWN - VAN BEERS</u>		14. MOTHER'S MAIDEN NAME <u>MARY - UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>489-09-9997</u>	
17. INFORMANT <u>Catherine Reuter R.R-1-Box 2890</u>			Address <u>Improm. Mo</u>
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>CEREBRAL THROMBOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>332X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 _____ a. m. _____ p. m. _____			
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>7/2/57</u> to <u>7/20/57</u> and last saw her alive on <u>7/20/57</u> Death occurred at <u>11:20 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. William D. Burch M.D.</u>		22b. ADDRESS <u>1515 Lafayette Ave.</u>	
		22c. DATE SIGNED <u>7/22/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-25-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL Cem</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>JAY-B-SMITH. Maplewood - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 23 57</u>	
		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D. S.P.</u>	

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 *J. Allen Davis*
Licensed Embalmer No. *49*

P. O. Address *W. J. ...*

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.