

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH34364  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2175

1. PLACE OF DEATH a. COUNTY <u>St. Louis</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>Clayton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>University City</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>County Hosp.</u> Length of stay in lb <u>4 days</u>		d. STREET ADDRESS (If outside, give location) <u>8485 Kemland</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Beauke</u> Last <u>Borden</u>			4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>F.</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>Aug 13, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTH PLACE (City and state or country) <u>Krakow, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Beauke</u>			14. MOTHER'S MAIDEN NAME <u>Helene</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>555-28-9051</u>		17. INFORMANT Address <u>Robert Wilson - 8485 Kemland</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 Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause. (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Arteriosclerotic Heart Disease</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 _____ Month _____ Day _____ Year _____ 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>8-26-1957</u> to <u>8-30-1957</u> and last saw her/him alive on <u>8-30-1957</u> Death occurred at <u>9:00 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Date or title) <u>James H. Page, M.D.</u>		22b. ADDRESS <u>601 S. Brentwood Blvd.</u>		22c. DATE SIGNED <u>8-31-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-4-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Golden Gate National</u>	23d. LOCATION (City, town, or county) (State) <u>San Bruno, California</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Bauman Bros. Overland, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-1-57</u>	26. REGISTRAR'S SIGNATURE <u>Arthur A. Donk</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. 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

MEDICAL CERTIFICATION

49.

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.....  
*David C. Gibson*

Licensed Embalmer No. *340*

P. O. Address *Overland*

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.