

pt. Health,
& Welfare
S. Public
Health Service

S. 300
ev. 1-56

Securing the medical certificate in the specific manner required by 193.140 MoRS 1949.

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 26 1957

41621
STATE FILE NUMBER

Registration District No. 309 Primary Registration District No. 44-5-5 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Portage des Sioux		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Portage des Sioux		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Box 13			Length of stay in lb 3 yrs.		d. STREET ADDRESS (If outside, give location) Box 13			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lillian Middle M. Last Beardsley				4. DATE OF DEATH Month 10 Day 24 Year 57				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1875		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Weedman				14. MOTHER'S MAIDEN NAME Mary unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Dorothy Schomaker			Address Portage des Sioux
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pharynx Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic glomerulonephritis DUE TO (c) Glomerulonephritis							INTERVAL BETWEEN ONSET AND DEATH 20 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 592X							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 <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 July 1955 to Oct. 21-57 and last saw her/him alive on Oct 18-57 Death occurred at 9:45 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) D. J. ...				22b. ADDRESS 2045 M' ...			22c. DATE SIGNED 10-24-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10/26/57	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) St. Louis County		STATE MO.	
24. FUNERAL DIRECTOR Drehmann-Harral			ADDRESS 1905 Union		25. DATE RECD. BY LOCAL REG. Oct 26 1957		26. REGISTRAR'S SIGNATURE D. J. ...	

Dr. Thomas
2045 McLaren

Hrs. 2 - 5 Thurs.

NOV 27 1957

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 *Albert R. Thompson*

Licensed Embalmer No. 42

P. O. Address *H. J. ...*

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.