

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006998  
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2248

300  
1-57

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All diseases in Part I must be causally related.

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>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #2.</u>		Length of stay in lb <u>#2.</u>	d. STREET ADDRESS (If outside, give location) <u>22570 901 PINE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY BEAN</u>			4. DATE OF DEATH Month Day Year <u>FEB. 20, 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>6-24-97</u>
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COURT REPORTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>NORRISTOWN, PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>ASHER BEAN</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA</u>
14. NAME OF HUSBAND OR WIFE <u>ETHEL BEAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, in or out of service) (If yes, give name of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>NR</u>
17. INFORMANT <u>ETHEL BEAN</u>		Address <u>3001 Ramothan</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>MASSIVE PULMONARY EMBOLI;</u> DUE TO (b) <u>THROMBOPNEBITIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>FRONTAL LOBE TUMOR OF BRAIN</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>1/27/58</u> to <u>2/20/58</u> and last saw her/him alive on <u>2/20/58</u> Death occurred at <u>5:15 A.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>2/20/58.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2/25/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>JEFF. CO., MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>EPW. FENDLER 5611 DOB GRAND</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 25 58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> The R.B.

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 *Prof. Embalmer*  
*Edw. J. J. J.* .....

Licensed Embalmer No. ....

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.