

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008143
STATE FILE NUMBER

FILED MAR 12 1958

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 608

300

-57

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKWOOD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN BRENTWOOD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH Hosp		Length of stay in 1b 1HR	d. STREET ADDRESS (If outside, give location) 8612 FLORENCE
3. NAME OF DECEASED (Type or print) First EUGENE Middle R Last BECKER		4. DATE OF DEATH Month 2 Day 24 Year 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 16 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MFG.		10b. KIND OF BUSINESS OR INDUSTRY DRUG MFG.	9. AGE (In years last birthday) 77
11. BIRTHPLACE (City and state or country) ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME CARL BECKER		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE LILLIAN M. BECKER
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. UNKNOWN	17. INFORMANT Address MRS. H. C. SCHREWING, SR-8601 JOSEPH.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) acute pulmonary edema DUE TO (c) acute Posterior Septal Infarct 4200			INTERVAL BETWEEN ONSET AND DEATH 5-7 days 12 hours 4 years 4 years
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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 1-12-58 to 2-24-58 and last saw her alive on 2-24-58 Death occurred at 6:30 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) E. M. Call M.D.		22b. ADDRESS Brentwood Mo	22c. DATE SIGNED 2-25-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-27-58	23c. NAME OF CEMETERY OR CREMATORY HIRAM CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS Co Mo
24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH Maplewood 17 Mo		25. DATE RECD. BY LOCAL REG. 2-27-58	26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

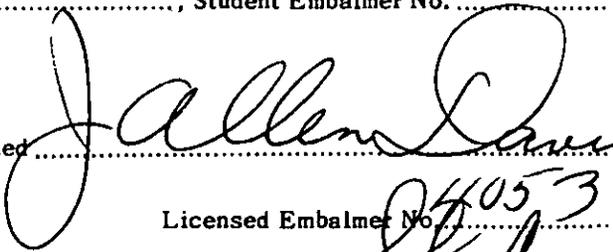
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

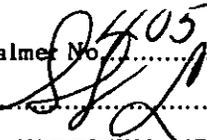
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 4053

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.