

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030141

STATE FILE NUMBER
8243

FILED AUG 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

| | | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY - - - | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY 1 | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis, | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hosp. | | Length of stay in lb 17 Days | | d. STREET ADDRESS (If outside, give location) 5707 Cote Brilliance | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Bean Last Bean | | | | 4. DATE OF DEATH Month August Day 23 Year 1958 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 8-1877 | | 9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) St. Louis County, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME William | | | 13b. MOTHER'S MAIDEN NAME Mary | | 14. NAME OF HUSBAND OR WIFE - - - | | | |
| 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. 190-28-7012 | | 17. INFORMANT Address, Geo. E. Bean 5707 Cote Brilliant Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs. | | |
| 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 (a) Decubitus Ulcer | | | | | | 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 for PART II of item 18.) 17 days | | | | | |
| 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 August 6, 1958 to August 23, 1958 Death occurred at 4:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | Good last saw her alive on August 23, 1958 him | | | | |
| 22a. SIGNATURE (Degree or title) John W. Beckham, M.D. | | | 22b. ADDRESS 5800 Arsenal | | | 22c. DATE SIGNED, 8/23/58 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/25/1958 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Mo. | | | |
| 24. FUNERAL DIRECTOR Arthur J. Donnelly | | | ADDRESS 3840 Lindell | | 25. DATE REC'D. BY LOCAL REG. AUG 25 '58 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1-57

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1959

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 *[Handwritten Signature]*

Licensed Embalmer No. 4699

P. O. Address 3840 ...

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.