

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030144

STATE FILE NUMBER 8365

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 St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Kirkwood 4683	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 32 St. Lukes		d. STREET ADDRESS (If outside, give location) 317 N. Essex	
3. NAME OF DECEASED (Type or print) First Middle Last William F. Beckman		4. DATE OF DEATH Month Day Year Aug 28, 1958	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Packaging Business	11. BIRTHPLACE (City and state or country) Nebraska U.S.A.
13a. FATHER'S NAME Fred Beckman		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Emma Beckman
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. 69-043-0170	17. INFORMANT Address Emma Beckman 317 Essex 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) Pneumococcal Embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Unknown DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) 465x			INTERVAL BETWEEN ONSET AND DEATH 10 min
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 11:30 am on 8/27/58 to 8/28/58 and last saw her alive on 8/27/58 m on the date stated above; and to the best of my knowledge, from the cause stated.			
22a. SIGNATURE J. B. Beare (Degree or title) M.D. O.D. J. B. Beare M.D.		22b. ADDRESS 3720 Wash - Ave St. Louis, Mo.	
22c. DATE SIGNED 8/29		23a. BURLIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Aug. 30, 1958		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	
23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		24. FUNERAL DIRECTOR Buell - Campbell Mortuary 5165 Delmar	
24. ADDRESS 5165 Delmar		25. DATE RECD. BY LOCAL REG. AUG 29 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Laurence O. Geshling*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis*

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.