

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002714  
STATE FILE NUMBER 938

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**FILED FEB 10 1959**

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</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> R159
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Length of stay in lb <u>D.O.A.</u>	d. STREET ADDRESS (If outside, give location) <u>4550 Morganford Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>BARBARA</u> Last <u>BEATY</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>1959</u>
5. SEX <u>Female</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>March 2, 1923</u>
9. AGE (In years last birthday) <u>35</u>		10. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Weiner</u>	
13b. MOTHER'S MAIDEN NAME <u>Sophia Hollenberg</u>		14. NAME OF HUSBAND OR WIFE <u>Kern Beaty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Kern Beaty</u>		Address <u>4550 Morganford Rd.</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>Gunshot wound of skull and brain.</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>E976x</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Self inflicted in home on</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I, PART II, or item 18.) <u>January 26 1959. While suffering from temporary mental aberration.</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>1 26 59</u>	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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ <u>9:15 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or title) <u>Tatrick Taylor Carauer</u>	
22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>1. 27. 59.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Kriegshausler 4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith MO.</u>

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 *William A. White* .....

Licensed Embalmer No. *4391* .....

P. O. Address *228 N. King St. Memphis* .....

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.