

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002722

STATE FILE NUMBER

2 747

FILED FEB 10 1959

Registration District No.

Primary Registration District No.

Registration No.

300
1-57
38
42
3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</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>ENROUTE LUTHERAN Hosp.</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>2249 2811 JUNIATA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>REV. THEODOR E. BEIER</u>			4. DATE OF DEATH Month Day Year <u>JAN. 19 1959</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>OCT. 14 1904</u>	9. AGE (In years last birthday) <u>54</u>	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PASTOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ST. ANDREWS EV. CH.</u>	11. BIRTHPLACE (City and state or country) <u>IOWA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>EMIL BEIER</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>LAURA BEIER</u>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>LAURA BEIER 2811 JUNIATA</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>Acute myocardial infarction due to arteriosclerotic coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic coronary heart disease with decompensation</u> DUE TO (c) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 days.</u>
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? 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 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>11-2-55</u> to <u>1-19-59</u> and last saw her/him alive on <u>1-14-59</u> Death occurred at <u>4:15 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. J. Kuth</u> (Degree or title) M.D.	22b. ADDRESS <u>634 N. Grand Blvd.</u>	22c. DATE SIGNED <u>1/22/59</u>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JAN. 23 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
---	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>Thomas Kuth 2906 Gravis</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 22 59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>
--	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2-4 PM. a.m.
J-8-7469

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 *Eleana Poivice*

Licensed Embalmer No. *3403*
P. O. Address *Jennings*

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.