

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003938

STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 206

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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> 210 <sup>0</sup>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic</u>		Length of stay in lb <u>10 days</u>	d. STREET ADDRESS (If outside, give location) <u>7224 W. Sacramento</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Johanna</u> Middle <u>Beiter</u> Last <u>Beiter</u>			4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-93</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</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>John Hilf Meyer</u>		13b. MOTHER'S MAIDEN NAME <u>?</u>		14. NAME OF HUSBAND OR WIFE <u>George (deceased)</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 <u>John C. Beiter</u> Address <u>8543 RIVERVIEW</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>Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Occlusion et Myocardial Infarctions</u>		
DUE TO (c) <u>Arteriosclerosis - Hypertension 420.1</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 <u>—</u> Month, Day, Year a.m. <u>—</u> p.m. <u>—</u>		

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 <u>ST. LOUIS</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
21. I attended the deceased from <u>June 1958</u> to <u>1/20/59</u> and last saw her/him alive on <u>1/20/59</u> . Death occurred at <u>4:10 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Jay A Kilpatrick</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>4601 A Pope Ave, St. Louis, Mo</u>	22c. DATE SIGNED <u>1/20/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 22, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>

24. FUNERAL DIRECTOR <u>Wedmeyer &amp; Son</u>	ADDRESS <u>3934 W. 20th</u>	25. DATE RECD. BY LOCAL REG. <u>1-21-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(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 *Harvey Kahle* .....

Licensed Embalmer No. *4596*.....  
P. O. Address *Flouissant, Mo*.....

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.