Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014674
STATE FILE NUMBER

FILED APR 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3373

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN: ST LOUIS — Inside Limits: Yes [X] No [ ] c. FULL NAME OF HOSPITAL OR INSTITUTION: ST LOUIS CITY HOSP # 1 — Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY c. CITY OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ] d. STREET ADDRESS (If outside, give location): 3426 So. Compton — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First WILLIAM Middle EVERMONT Last BECK

4. DATE OF DEATH: Month APRIL Day 3, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 8, 1897

9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): employee

10b. KIND OF BUSINESS OR INDUSTRY: Post-Office

11. BIRTHPLACE (City and state or country): Pinckneyville, Illinois

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Fred. Beck

13b. MOTHER'S MAIDEN NAME: Frankie Jameson

14. NAME OF HUSBAND OR WIFE: Marie S. Meyer Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Marie Beck - 3426 So. Compton Ave. Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chronic glomerulonephritis — years

DUE TO (c) 592X

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 [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 MAR 20, 1959, to April 3, 1959 and last saw her/him alive on APRIL 3, 1959

Death occurred at 7:20P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. L. Thurner, M.D. (Degree or title)

22b. ADDRESS: 1515 Lafayette Ave

22c. DATE SIGNED: 4-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Apr.6,1959

23c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis, Missouri

24. FUNERAL DIRECTOR: WACKER-HELDERLE — ADDRESS: 3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG.: APR 6 '59

26. REGISTRAR'S SIGNATURE: Karl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Felix J. Krispin

Licensed Embalmer No. 349

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.