

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018928
STATE FILE NUMBER
2 4420

FILED MAY 25 1959 Registration District No. Primary Registration District No. Registrar No.

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says death
HP's
writing
Police

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, MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS 4281
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 So. GRAND		Length of stay in 1b 13 days	d. STREET ADDRESS (If outside, give location) 7410 PAGE BLVD

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH T. BECKER			4. DATE OF DEATH Month Day Year 5 4 59			
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 7/27/91	9. AGE (In years last birthday) 67	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) BRICKLAYER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (City and state or country) LEAVENWORTH, KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME GEORGE BECKER		13b. MOTHER'S MAIDEN NAME ALPHA SANDS		14. NAME OF HUSBAND OR WIFE GRACE BECKER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give number of service) YES WWI		16. SOCIAL SECURITY NO. 498-18-7130		17. INFORMANT Address VAH, 915 So. GRAND ST. LOUIS, MO		

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>HYPERTENSIVE CARDIOVASCULAR DISEASE 15 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>FRACTURE OF SIXTH & SEVENTH CERVICAL VERTEBRAE</u>		

20a. ACCIDENT <input checked="" 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.) <u>auto accident at Brown Rd. and Natural Bridge - St. Louis Co. Mo. 400</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>6:45 a.m. 4-20-59</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.) <u>35 auto</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis Co. Mo.</u>
21. I attended the deceased from <u>4/21/59</u> to <u>5/4/59</u> and last saw him alive on <u>5/4/59</u> Death occurred at <u>11:40 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated		
22a. SIGNATURE (Degree or title) <u>Joseph M. Smith</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>5/5/59</u>

22d. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	23d. LOCATION (City, town, or county) (Site) <u>ST. LOUIS COUNTY MO</u>
24. FUNERAL DIRECTOR <u>C.R. LINDEN & SONS</u>	ADDRESS <u>7232 DELMAR</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 5 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loel Smith, M.D.</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 *Arnold W. Schone*

Licensed Embalmer No. *3864*
P. O. Address *St. Louis, 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.