RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-026394

FILED VS AUG 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 6628

STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 5 DAYS

c. CITY OR TOWN Lemay — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hosp. — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 606 Kayser — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Henry Peter Becker

4. DATE OF DEATH Month Day Year: 7- 13- 1959

5. SEX: M

6. COLOR OR RACE: W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 4-30-80

9. AGE (last birthday): 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY: Gen'l Trucking

11. BIRTHPLACE (City and state or country): Unknown

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

13a. FATHER'S NAME: Peter F. Becker

13b. MOTHER'S MAIDEN NAME: Dora Westerman

14. NAME OF HUSBAND OR WIFE: Lena Becker

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

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Hulda Telthorst Affton, Mo. — Address 6622 Kingsway Dr.

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

PART I. DEATH WAS CAUSED BY: acute dilation of heart

IMMEDIATE CAUSE (a) acute dilation of heart

chr. cardiovascular heart disease

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

DUE TO (b) chronic cardio vascular heart disease

DUE TO (c) 422.1

INTERVAL BETWEEN ONSET AND DEATH: 2 hrs; several yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): hypostatic pneumonia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ 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 1-2-59, to July 13 59 and last saw her/him alive on July 13 59

Death occurred at 6:35 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Erwin D. Crecelius M.D.

22b. ADDRESS: 752 Lemay Ferry Rd.

22c. DATE SIGNED: 7/14/59

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

23b. DATE: 7-16-59

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer

23d. LOCATION (City, town, or county) (State): Rt 1 - DeSoto Mo

24. FUNERAL DIRECTOR ADDRESS: J. Lee Mothershead, DeSoto, Mo.

25. DATE RECD. BY LOCAL REG.: JUL 15 59

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

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Andrew H. Englam

Signature of Student Embalmer

Licensed Embalmer No. 4745

P. O. Address De Soto, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.