URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1959

59-033558

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8752

ENDED

1. PLACE OF DEATH
a. COUNTY

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

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

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

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

d. STREET ADDRESS (If outside, give location) 5370 Pershing — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Dr. Middle EDMUND Last NORRIS BEALL

4. DATE OF DEATH Month Sept. Day 2 2, Year 1959

5. SEX M

6. COLOR OR RACE W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 6/28/75

9. AGE (last birthday) 84 — 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) Dentist Self Employed

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Capt. George T Beall

13b. MOTHER'S MAIDEN NAME Elizabeth Norris

14. NAME OF HUSBAND OR WIFE Grace McIntyre Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs. Grace Beall 5370 Pershing

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH survival years

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

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) 420.0

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

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 July 18 '59, to Sept 22 59 and last saw her him alive on Sept 15 '59

Death occurred at 5:10 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Samuel B. Grant (Degree or title) M.D. M.D.

22b. ADDRESS 114 No. Taylor 114 N Taylor Ave

22c. DATE SIGNED 9-22-59

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

23b. DATE Sept 24, 1959

23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery

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

24. FUNERAL DIRECTOR ADDRESS ALEXANDER & SONS 6175 Delmar

25. DATE RECD. BY LOCAL REG. SEP 25 '59

26. REGISTRAR'S SIGNATURE Earl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

Dr. Sam Grant

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_____
Signature of Student Embalmer

Signed Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6175 Ellm

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.