

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017054

FILED VS MAY 2 1960

Primary Registration District No. Registrar's No. 2 2549

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2001 Pestalozzi</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle Last <u>Lehmann</u>			4. DATE OF DEATH Month <u>Mar</u> Day <u>4</u> Year <u>1960</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"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/10</u>	9. AGE (last birthday) <u>49</u>	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St Louis Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U S</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>Anton Broz</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Nemas</u>	14. NAME OF HUSBAND OR WIFE <u>Frank (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.	17. INFORMANT <u>A W Broz 14 D Lakeshore Dr</u>	Address <u>House Springs Mo</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>Drug poisoning (nature of which is undetermined) self-ingested at her home at 2001² Pestalozzi on March 4, 1960 while suffering from temporary mental aberration</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Suicide</u>	
	DUE TO (c)	

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	---

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>(See above)</u>
---	--	--

20c. TIME OF INJURY Hour <u>3-4-60</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Missouri</u>	STATE
--	---	---	--	---------------------------	-------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 7:30 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Patrick E. Taylor Corcoran</u> (Degree or title)	22b. ADDRESS <u>1340 Clark</u>	22c. DATE SIGNED <u>3-4-60</u>
---	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/7/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Brks Missouri</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>Moydell Funeral Home 1926 Allen</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR 4 1960</u>	26. REGISTAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	---------	---	---

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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

Hadley F. Keller Jr

Licensed Embalmer No. 4950

P. O. Address St. Louis

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