

PL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS JAUG 8 1960

-60-028999

DED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2284

STATE FILE NUMBER

|  |   |   |  |   |  |   |  |
|--|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u> |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>WEBSTER GROVES</u>   |   | Length of stay in 1b<br><u>YRS.</u>   |  | c. CITY OR TOWN <u>WEBSTER GROVES</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>AT HOME-826 LILAC</u>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | d. STREET ADDRESS (If outside, give location)<br><u>826 LILAC AVE.</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>FRANK C. BECKER</u>   |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>JULY 29, 1960</u>  |  |   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4/28/1896</u>  | 9. AGE (last birthday)<br><u>64</u>  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MANAGER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>LIQUID CARBONIC</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>LEXINGTON, MO.</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>EVAN BECKER</u>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>MARY BELLE NICHOLSON</u>                                     |   | 14. NAME OF HUSBAND OR WIFE<br><u>ORPHA G. BECKER</u>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>YES</u>   |   | 16. SOCIAL SECURITY NO.<br><u>W.W.I 487-03-6955</u>   |  | 17. INFORMANT<br>Address<br><u>MRS. F. C. BECKER, 826 LILAC, W.G., MO.</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid colon with metastases</u>  |   |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u> |
| 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)  |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input 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.) |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |   |   |  |   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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.)  |  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY STATE  |  |
| 21. I attended the deceased from <u>Aug 6 1958</u> to <u>July 29, 1960</u> and last saw him alive on <u>July 29, 1960</u><br>Death occurred at <u>3:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>James B. Jones, M.D.</u>  |   |   |  | 22b. ADDRESS <u>9313 Manchester Rd St Louis 19, Mo.</u>   |  | 22c. DATE SIGNED<br><u>7-30-60</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 23b. DATE<br><u>8/1/1960</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ROSE HILL CEMETERY</u>   |  | 23d. LOCATION (City, town, or county)<br><u>TULSA, OKLA.</u>  |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br><u>PARKER-ALDRICH, WEBSTER GROVES, MO.</u>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>7-30-60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>John B. Murphy 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Leslie Welch*

Licensed Embalmer No. 439

P. O. Address Wester \*

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