RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-044585

STATE FILE NUMBER

FILED VS NOV 17 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3086

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights — Length of stay in 1b	c. CITY OR TOWN St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital — Inside Limits Yes X No ☐	d. STREET ADDRESS (If outside, give location) 3645 Utah Pl. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Robert	Russell	Bechler	Oct.	22,	1960

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed X Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Male	White		9/17/25	35				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
draftsman	------	St. Louis, Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
William Bechler	Amanda Fabry	Corinne Ward Bechler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	W.W. #2	unknown	James L. Bechler	3645 No. Utah Pl.

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carbon Tetrachloride Poisoning — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

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

894.0 -15

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☐	20a. ACCIDENT X	SUICIDE ☐	HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Inhalation While Cleaning Furniture (at home)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
	10/8/60		In Home	St. Louis	Mo.	

21. I attended the deceased from 1947, to 10/22/60 and last saw ~~her~~ him alive on 10/22/60

Death occurred at 6:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
John M. Demme	MD	6500 Chippewa St. L. Mo.	10/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	Oct. 26, 1960	National Cemetery	Jefferson Barracks,	Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
WACKER-HELDERLE	3634 Gravois Ave.	10-25-60	John C. Murphy Md.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 _____

Licensed Embalmer No. 2375

P. O. Address St. Louis 27,

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.