

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

9729-61-038280

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>KIRKWOOD</b>	
Length of stay in lb <b>DOA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D. O. A. City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>419 E ARGONNE DR.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>BEECHER</b> Last <b>BEECHER</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>20</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/1879</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beecher-Maxwell Adv Co</b>		11. BIRTHPLACE (City and state or country) <b>Washington Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>US</b>		13a. FATHER'S NAME <b>James Beecher</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Parker</b>	
14. NAME OF HUSBAND OR WIFE <b>Mae Beecher</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
17. INFORMANT <b>Mrs Mae Beecher</b>		Address <b>419 E Argonne Dr Kirkwood</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)	<b>Cerebrovascular accident</b>	INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
DUE TO (b)	<b>Generalized arteriosclerosis</b>	<b>10 years</b>
DUE TO (c)	<b>331x</b>	

Conditions, many, which may rise to above cause (a), state the underlying cause last.

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 <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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from **1955** to **Oct. 20, 1961** and last saw him alive on **Oct. 3, 1961**  
Death occurred at **10:30 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Augustine James M.D.</b>	(Degree or title)	22b. ADDRESS <b>3720 Washington Ave St. Louis Mo</b>	22c. DATE SIGNED <b>10-21-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>10/23/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Louis H. Boop Inc Kirkwood Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 21 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>
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DATE AMENDED

INSTEAD OF DOCUMENT

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Francis J. [Signature]*

Licensed Embalmer No. 4512

P. O. Address Richwood, W. Va.

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