

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-046062**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**318**

**1003**

**11520**

STATE FILE NUMBER

AMENDED

**FILED DEC 18 1961**

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in 1b <b>4 days</b>		c. CITY OR TOWN <b>Chester</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>140 Opdyke</b>	
3. NAME OF DECEASED (Type or print) First <b>SELMA</b> Middle <b>(none)</b> Last <b>BEARE</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>8,</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/24/86</b>	
9. AGE (last birthday) <b>75</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Ellis Grove, Ill.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13a. FATHER'S NAME <b>Dr. Henry Boldt</b>				13b. MOTHER'S MAIDEN NAME <b>Sophia Rauch</b>		14. NAME OF HUSBAND OR WIFE <b>Dr. J. W. Beare</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Dr. Byron Beare - St. Louis, Mo.</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>Retinoblastoma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>250-0</b>							
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 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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 <b>4/7/58</b> to <b>death</b> and last saw her/him alive on <b>12/2/61</b> Death occurred at <b>10:00 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert Parris M.D.</b>				22b. ADDRESS <b>3720 Washington, St Louis</b>		22c. DATE SIGNED <b>12/9/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Catholic</b>		23d. LOCATION (City, town, or county) (State) <b>Chester, Illinois</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Welge Fnr1. Home - Chester, Ill.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 11 1961</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith. M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

NEW NO.

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 Mark Embalsmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed John J. Kasaly III

Licensed Embalmer No. 5039

P. O. Address E. St Louis, Mo.

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.