

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003466

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 505 STATE FILE NUMBER

AMENDED

FILED JAN 19 1962

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH: a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> 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> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3939a Gravois Ave.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3939a Gravois Ave.</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Beare</u> Last | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>11,</u> Year <u>1962</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>11/4/81</u> |
| 9. AGE (last birthday) <u>80</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>housekeeping</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>George Deffaa</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sherman Beare</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. <u>unknown</u> | 17. INFORMANT Address <u>William Hartmann-3939a Gravois Ave.</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>Cerebral Hemorrhage Left 1st</u> DUE TO (b) <u>Arterio-sclerotic Heart Disease ? HTS.</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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 <u>9-13-54</u> to <u>1-11-62</u> and last saw her alive on <u>1-10-62</u> Death occurred at <u>5:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Wacker-Helderle M.D.</u> | | 22b. ADDRESS <u>4500 Olive St. Louis 8 Mo</u> | 22c. DATE SIGNED <u>1-12-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Jan. 15, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>WACKER-HELDERLE-3634 Gravois Ave.</u> | | 25. DATE RECD. BY LOCAL REG. <u>JAN 12 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u> |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 Philip J. Kuspri

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.