

MISSOURI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

FILED JAN 19 1962

-62-003467

318

1003

334

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			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 St. Louis		Length of stay in 1b 75 yrs	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2228 Montana Avenue		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2228 Montana Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JULIA Middle C. Last BECK			4. DATE OF DEATH Month Jan. Day 7, Year 1962		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1878	9. AGE (last birthday) 83	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) housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) Wittenberg, Germany	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Beck		13b. MOTHER'S MAIDEN NAME Barbara Eisenlohn		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Katherine Nackenhorst, 10519 Wisteria	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) General arteriosclerosis DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 5 years 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Influenza				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 3-26-60 to 1-8-62 and last saw her alive on 1-6-62 Death occurred at 1:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Oley S Jones M.D. (Degree or title)			22b. ADDRESS 3616 S Bldg St Louis		22c. DATE SIGNED 1-8-62
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE 1/10/62	23c. NAME OF CEMETERY OR CREMATORY Valhalla Chapel of Memories		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H.INC., 1936 St. Louis Ave.		ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 9 1962	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

Dr. O. S. Jones
3616 So. Broadway
PR 2-5626

1-4 PM

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 Homer W. Jintz

Licensed Embalmer No. 3882

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.