

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6827163-025648**

FILED JUL 5 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY St. Louis Missouri</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Missouri Length of stay in 1b.</p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri COUNTY</p> <p>c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 6435a Idaho Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last Leonard C. Beck</p>	
<p>4. DATE OF DEATH Month Day Year June 27, 1963</p>	
<p>5. SEX male</p>	<p>6. COLOR OR RACE white</p>
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Mar. 29, 1892</p>
<p>9. AGE (last birthday) 71 IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.</p>	<p>11. BIRTHPLACE (City and state or country) Stxxkau Missouri</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Inspector, Union Electric</p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY Stxxkau Missouri</p>	
<p>12. CITIZEN OF WHAT COUNTRY USA</p>	
<p>13a. FATHER'S NAME James Beck</p>	<p>13b. MOTHER'S MAIDEN NAME Mary Ella Farrar</p>
<p>14. NAME OF HUSBAND OR WIFE Ethelean Beck</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no</p>	<p>16. SOCIAL SECURITY NO. unk</p>
<p>17. INFORMANT Ethelean Beck Address 6435a Idaho</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) MASSIVE RIGHT LOWER LOBE PNEUMONIA</p> <p style="text-align: center;">DUE TO (b) PANCOAST TUMOR Left Upper Lung</p> <p style="text-align: center;">DUE TO (c) INVASION of Left Atrial Apex</p> <p style="text-align: right;">INTERVAL BETWEEN ONSET AND DEATH 48 HRS</p> <p style="text-align: right;">1 year</p>	
<p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p style="text-align: right;">1621</p>	
<p style="text-align: right;">PART III. (If deceased was female was there a pregnancy in last 90 days.)</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour . Month, Day, Year. a.m. p.m.</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from 1957, to 6/27/63 and last saw him live on 6/27/63</p> <p>Death occurred at 1225 P.M. on the date stated above, and to the best of my knowledge, from the causes stated:</p>	
<p>22a. SIGNATURE (Degree or title) Charles Blood</p>	<p>22b. ADDRESS 3438 S. GRAND BLVD.</p>
<p>22c. DATE SIGNED 6/28/63</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) removal</p>	<p>23b. DATE 7-1-63</p>
<p>23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.</p>	
<p>23d. LOCATION (City, town, or county) (State) Lemay, Mo.</p>	
<p>24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home</p>	<p>25. DATE RECD. BY LOCAL REG. JUN 29 1963</p>
<p>26. REGISTRAR'S SIGNATURE Loed Smith M.D.</p>	

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
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 USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

Dr. Chris Ladd
3438 S. Mans

1 to 4.

BR 1-7388

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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 So. Grand

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.