WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 3047

Township ..... Primary Registration District No. 1003 Registered No. 639

City St. Louis. (No. 5129 @ S. Compton Avenue, St. ..... Ward)

2. FULL NAME William Beehl.

(a) Residence. No. 5129@ S. Compton Ave. St., 15 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 23.1902.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
24	5	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ice and Coal delivery

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Andrew Beehl.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Anna Waidmann.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Louis, V. Kelly (Address) 5129@ S. Compton Avenue.

15. FILED JAN 19 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1/17

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/17 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 4-30 P.M. 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound of Head

167 Suicide (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

170

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H W Faile M.D.

1/18, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: SS. Peter & Paul Ceretery

DATE OF BURIAL: Jan. 20, 1927

20. UNDERTAKER: J H Gibson L. and H. Co

ADDRESS: 2842 Meramec