

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

Do not use this space.

NOV 13 1934

37944

**1. PLACE OF DEATH**

County ..... Registration District No. **791**  
Township ..... Primary Registration District No. **1003**  
City **St. Louis** (No. **Christian Hospital**) St. .... Ward .....

File No. ....  
Registered **10438**  
St. .... Ward .....

**2. FULL NAME**

**Patricia Ann Beckman**  
(a) Residence, No. **5066<sup>a</sup> Buckin Ave St.** Ward. **7**

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **4 yrs. 9 mos. 14 ds.** How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 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 **Child**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 13, 1930**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
**4 9 14**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Child**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

13. NAME **Fred Beckman**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

15. MAIDEN NAME **Ann Campbell**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Clayton Mo.**

17. INFORMANT **Fred Beckman** (ADDRESS) **5066<sup>a</sup> Buckin Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **Oct. 30, 1934**

19. UNDERTAKER **Wiedmer & Sons** (ADDRESS) **3754<sup>a</sup> W. 20<sup>th</sup> St.**

20. FILED **OCT 29 1934** 19 **J. Predeck** Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 27, 1934**

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

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at **5:30 P.M.**

The principal cause of death and related causes of importance were as follows:

**Bronchopneumonia**  
**107A**  
Other contributory causes of importance: **107A**

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? **✓** Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) **Harold P. Kelly** (Address) **1029<sup>a</sup> W. 20<sup>th</sup> St.**

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.

Were there any other complications, such as measles, whooping-cough, etc. Prior to or along with Bronbhopneumonia?

No

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis

Registration District No. 791

Township St. Louis

Primary Registration District No. 1003

City St. Louis

(No. Christian Hosp)

File No. \_\_\_\_\_

Registered No. 10432

St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Patricia Ann Beckman

(a) Residence, No. \_\_\_\_\_ St., \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>4</u>	<u>9</u>	<u>14</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 12-15-34 J F Brudeck Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 27, 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset \_\_\_\_\_  
Primary

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Y

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Harold H Schulz

(Address) Dep Car

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.