

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

MAR 13 1939

731
10034756
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **1449**
 (c) City **St. Louis** (d) Street No. **4963 Magnolia Ave.** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

550 Philomena Beynon
 (a) Residence, No. **4963 Magnolia Ave.** St. **13**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Late Jacob L. Beynon		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12, 1850		
7. AGE 88	YEARS 8	MONTHS 1
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
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 Anthony Cabrilliac		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) France		
15. MAIDEN NAME Augustine Frances		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Belgium		
17. INFORMANT Mrs. Aimee Martin (ADDRESS) 4963 Magnolia Ave.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE 2-15 19 39		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kriegshauser Mortuar 4228 So. Kingshighway		
20. FILED FEB 14 1939 J. D. Brudick Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2-13** 19**39**22. I HEREBY CERTIFY, That I attended deceased from **Mar. 10**, 19**34**, to **Feb. 12**, 19**39**I last saw her alive on **Feb. 12**, 19**39**. Death is said to have occurred on the date stated above, at **7:40 A. M.**

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

Intestinal NeoplasmicDate of onset
Long time

Other contributory causes of importance:

mitial (unspecified)

Name of operation..... Date of.....

What test confirmed diagnosis? **Chemical** Was there an autopsy?.....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) **Clifford T. Danvers** M. D.(Address) **7650 Duke Ave.**

Dr. Clifford Sanders

9050 Dale Ave
OK 2 P.M.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Edwin M. Dermott

Licensed Embalmer No.....

3024

P. O. Address.....

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 this body is not embalmed, above space should be left blank.