

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **8997**

1. PLACE OF DEATH: **1003**

(a) County **St. Louis**

(b) City or town **St. Louis**

(c) Name of hospital or institution: **City Hosp. #1**

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County \_\_\_\_\_

(c) City or town **St. Louis** [23]

(d) Street No. **2807<sup>1/2</sup> Victor St**

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME **Donald Beerhalter**<sup>643</sup>

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **April 9 1918**

8. AGE:	Years	Months	Days	If less than one day
	<b>21</b>	<b>6</b>	<b>11</b>	

9. Birthplace **St. Louis** (City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **William Beerhalter**

13. Birthplace **St. Louis Mo.**

14. Maiden name **Irene Toohy**

15. Birthplace **St. Louis Mo.**

16. (a) Informant's own signature **Wm. Beerhalter**

(b) Address **2807<sup>1/2</sup> Victor St.**

17. (a) **Burial** (b) Date thereof **Oct 23 1939**

(c) Place: burial or cremation **new St. Marcus Cem**

18. (a) Signature of funeral director **W. A. B. K. & Co.**

(b) Address **2929 S. Jefferson Av**

19. (a) **OCT 23 1939** (b) \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **20** year **1939** hour **1** minute **30** M.

21. I hereby certify that I attended the deceased from **1934** to **1939** no. **Oct 20 - 1939**

that I last saw him alive on **Oct 15 - 1939** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Embolus** Duration \_\_\_\_\_

Due to **Jacksonian Epilepsy 1 yr**

due to **Acquired (Communited skull fracture - in 1934) myocarditis**

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: **Removal of blood cyst at accepted region of autopsy of 1929.**

PHYSICIAN \_\_\_\_\_ Underlines the cause to which death should be charged statistically

22. If death was due to external cause, fill in the following:

(a) **accident, suicide, or homicide (specify) accident 1934**

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? **Public street**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **fell from truck on street**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **D. A. O'Connell** (M. D. or other) \_\_\_\_\_

Address **421 W. Schumers** Date signed **10/20/39**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

ROY 5-17-39 I X1511

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.

584

421 Schenck

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 Paul A. Shanklin working under my personal supervision.

Signed Paul A. Shanklin  
Registered Apprentice No. \_\_\_\_\_  
Licensed Embalmer No. 3472  
P. O. Address 2999 S. Jefferson

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.