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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUN 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17957

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 607

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 DAYS (Specify whether years, months or days)

In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 1416 Sacramento (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Robert Edward Beyers 620

3. (b) If veteran, name war None

3. (c) Social Security No. None

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 (Month) 13 (Day) 1939 (Year)

8. AGE: Years 1 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace St. Joseph (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business ____

FATHER
12. Name Joseph E. Beyers
13. Birthplace Kansas City (City, town, or county) Kansas. (State or foreign country)

MOTHER
14. Maiden name Marie A. Null
15. Birthplace St. Joseph (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Joseph E. Beyers

(b) Address 1416 Sacramento St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman Wm. Sidenfaden

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 6/3/40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31st year 1940 hour 11 minute 10 P M.

21. I hereby certify that I attended the deceased from May 25 1940, 19__, to May 31 1940, 19__; that I last saw him alive on May 31 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Inter cranial Hemorrhage (post operative)

Due to ____

Due to Internal Hydrocephalus (congenital)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Internal Hydrocephalus (congenital)

Of autopsy Inter cranial Hemorrhage

Duration

157 W

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

85

While at work? ____ (e) Means of injury ____

23. Signature [signature] (M. D. or other) 1

Address St. Joseph Mo Date signed 6.2.40

(Licensed Embalmer's Statement on Reverse Side)

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 Albert E. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

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.